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Beyond the Threshold: Wincing at Social Security's Process of Evaluating Pain

David J. Agatstein

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BEYOND THE THRESHOLD: WINCING AT SOCIAL SECURITY'S PROCESS OF EVALUATING PAIN

Judge David J. Agatstein*

Contents

| | |
|---------------------------------------|-----|
| I. Introduction | 233 |
| (a) Disability Determination | 233 |
| (b) Evaluating Pain | 234 |
| II. Mostly Medicine | 237 |
| (a) Algology, the Study of Pain | 237 |
| (b) The Experience of Pain | 242 |
| (c) Hard Cases | 245 |
| (1) Back Pain | 246 |
| (2) Headaches | 247 |
| (3) Fibromyalgia | 249 |
| (4) Somatoform Pain Disorder | 252 |
| (5) Chronic Pain Syndrome | 256 |
| (6) Malingering | 257 |
| (d) Management of Chronic Pain | 258 |
| III. Vocational Considerations | 259 |

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| | |
|--|-----|
| IV. The Law | 261 |
| (a) Evolution of Principles | 261 |
| (b) Evidentiary Considerations | 267 |
| (1) Overview | 267 |
| (i) Competence | 268 |
| (ii) Direct Observation: Sit & Squirm | 270 |
| (2) Evaluation of the Evidence | 271 |
| (i) Documents | 271 |
| (ii) Claimant's Testimony | 272 |
| (iii) Third-Party Evidence; Treating MD .. | 273 |
| (iv) Objective Tests for Pain | 274 |
| V. Conclusion | 276 |
| Appendix I: Treatment of Chronic Low Back Pain | 278 |
| Appendix II: Waddell's and other Tests for Malingering | 279 |
| Selected Bibliography | 280 |

Beyond the Threshold: Wincing at Social Security's Process of Evaluating Pain

I. Introduction

(a) Disability Determination

Social Security's process of disability evaluation is more complicated than tossing a suspected witch into the water, but it is not necessarily more valid. Both procedures achieve judicial determination of hypothetical "facts" which cannot be proven or disproven without reference to the procedure which defines these "facts." Stated somewhat differently, there is no scientific method by which the end result of either procedure can be tested against reality, or objectively falsified.¹

Judicial fact finding, of course, does not pretend to be an exact science. It must address issues which are not amenable to controlled experimentation or precise observation, and it does not, in any event, aspire to certainty.² For example, in America, material facts may be disregarded in the interests of confidentiality, freedom from unreasonable searches, or other important values. Cases frequently turn on subjective assessments of credibility. For this and other reasons, skeptical judges may prefer the dispute resolution function of adjudication to the fact finding role.

In Social Security's process of non-adversarial disability determination, there is an additional problem. It begins with the five

¹For example, a person may deny that he can work, and be adjudged "disabled," when, in fact, he can work and is working. If he is caught, he is subject to prosecution for fraud. However, some people work who have far more pathology than is necessary to qualify for benefits and, in some instances, a person can simultaneously work and lawfully receive disability benefits (trial work periods, Supplemental Security Income, etc.). The point is that "disability," in this context, is a legal artifact.

²It is worthwhile to recall that the scientific method originated with a distinguished judge, in relatively recent times. It is usually traced to the *Novum Organum* (1620) of Sir Francis Bacon. OXFORD COMPANION TO THE MIND 69.

questions of the "sequential evaluation."³ These questions are so general that considerable refinement is necessary before they can be applied to specific cases. The process of refinement begins in the regulations and continues in the course of litigation. Rules are divided and subdivided and fleshed out once again; the growth is reflected in lengthy treatises which invite the reader to believe that detailed, precise and relevant knowledge can be attained through diligent effort.⁴ The problem, however, is that there is no way of knowing whether the end result achieved by applying these rules is correct in reality, and some reason to believe that it is not.

As one philosopher pointed out, a map is not the territory;⁵ I interpret this to mean that a map of the Kingdom of Nowhere is not necessarily accurate, just because it is highly detailed. Add to this other logical deficits which pervade the Social Security disability system (some of which are discussed below), and a Judge's skepticism may give way to the nightmare that "sequential evaluation" is the process by which we dance around a claimant, shaking our feathers and rattles, while awaiting direction from the gods. This problem, I think, is well illustrated by the dilemma of evaluating pain.

(b) Evaluating Pain

In order to think clearly about this fascinating subject, it is important to avoid two common fallacies, and two apparent paradoxes, which lurk behind some of the bureaucratic writings and judicial decisions in this area. They are:

³These ask, basically, (1) Is the person working? (if so, he is not disabled). (2) If he is not working, is he sick? (If there is nothing wrong with him, we can stop here). (3) If he is sick, is he so sick that he obviously cannot work? (4) If he is not that sick, can he still do his former job? (5) If he cannot do his former job, is there other work he can perform? See 20 C.F.R. §§ 404.1520, 416.920 (1991).

⁴As Pierre Schlag put it, with respect to the American law in general, "the vastness and magnitude of the edifice made it difficult for anyone to believe that an enterprise possessed of so much information could be almost entirely bereft of knowledge or insight." Pierre Schlag, *Law and Phrenology*, 110 HARV. L. REV. 877, 909 (1997).

⁵ALFRED KORZYBSKI, *SCIENCE & SANITY: AN INTRODUCTION TO NON-ARISTOTELIAN SYSTEMS AND GENERAL SEMANTICS* 750 (4th ed. 1958). I believe that the concept originated with Emmanuel Kant, but I have been unable to locate the source.

(1) Reification, that is, the conversion of an abstract idea into a concrete thing. This is a particular problem in connection with the search for objective pain standards. To illustrate, it is obvious that a person's height and weight can be measured with great accuracy, using precise mathematical standards. It is also obvious that, when the words are used in this way, the person's "height" and "weight" are aspects of the individual, not independent qualities: There is no such thing as a person who does not have height and weight. While "there are rare individuals ... who are incapable of feeling [physical] pain,"⁶ when pain is present, it is an aspect of the individual, not an independent entity.⁷

The related paradox flows from this realization: There are specific nerve endings ("primary afferent nociceptors") which are activated by painful stimuli.⁸ If pain is not a separate entity, how can there be separate nerve pathways to receive it? As stated by a study committee of the Institute of Medicine of the National Academy of Sciences [hereinafter the "IOM"], "Nothing is known about how [painful] stimuli activate nociceptors."⁹

The paradox need not detain us, however, once it is realized that this is one instance of the philosophical question¹⁰ of how the outside world affects our consciousness through the medium of our senses. No one knows precisely how, at the fundamental molecular level, chemical and electrical activity translate into pain or analgesia. The important point is that pain (like depression, joy, or the reader's enthusiasm for this exciting article) is not a separate entity to be measured by itself.

(2) The second fallacy is even more important for disability analysis: It stems from the fact that we use the same word, "pain," to

⁶RAYMOND D. ADAMS & MAURICE VICTOR, *PRINCIPLES OF NEUROLOGY* 108 (3rd ed. 1985).

⁷BOAS, *HISTORY OF IDEAS* 31 (1969).

⁸PAIN AND DISABILITY: CLINICAL, BEHAVIORAL, AND PUBLIC POLICY PERSPECTIVES 124-25 (Marian Osterweis et al. eds., 1987). Referred to in the text as "IOM." Cf. ADAMS, *supra* note 6, at 116 (lack of organized receptors in eye and ear, and other apparently undifferentiated or partially differentiated receptors).

⁹*Id.* at 125.

¹⁰*See, e.g.,* JOHN LOCKE, *An Essay Concerning Human Understanding*; DAVID HUME, *An Enquiry Concerning Human Understanding*; IMMANUEL KANT, *Critique of Pure Reason*; D. Chalmers & J. Searle, *Consciousness and the Philosophers: an Exchange*, N.Y. REV. OF BOOKS, May 17, 1997, at 60.

describe what I contend are (or may be) entirely different phenomena. Hot stoves, spicy foods,¹¹ bad jokes, and a guilty conscience give rise to "painful" experiences that may have no more in common than tug boats and gravy boats. This distinction (which is frequently overlooked) may be useful in preventing rules intended for one type of "pain," e.g., mechanical pain, from being misapplied to, e.g., psychic pain.¹²

The distinction resolves the second apparent paradox: The regulation requires a medically determinable impairment, supported by medical signs or laboratory findings, that could reasonably be expected to produce pain.¹³ However, the regulations also set forth a listing for somatoform pain disorder¹⁴ in which "psychological factors are judged to have the major role in the onset, severity, exacerbation, or maintenance of pain."¹⁵ The diagnosis is made on the basis of symptoms alone. I contend that the apparent conflict in these rules results from the fact that they are speaking to entirely different experiences, both of which are expressed as a sensation of "pain."

Finally, the distinction, where appropriate, makes a difference. While it is true that we evaluate all symptoms that a case presents, and therefore all experiences that go under the name of "pain," not all emotive states or free floating symptoms give rise to disability, even if they are associated with a medically determinable impairment. For example, dysphoria (a bad mood), or toothache, may be less pervasive and intractable than cancer pain. In order for pain to be properly analyzed, I contend that it must be linked to its cause.

With these thoughts in mind, it may now be useful to outline the pain experience from inception to resolution or otherwise.¹⁶

¹¹ADAMS, *supra* note 6, at 107.

¹²See, e.g., A. Donagan, *Wittgenstein on Sensation*, in WITTGENSTEIN, THE PHILOSOPHICAL INVESTIGATIONS 324 n.l. (G. Pitcher ed., 1968).

¹³20 C.F.R. §§ 404.1529(b), 416.929(b) (1991).

¹⁴20 C.F.R. Pt. 220, App. 1, listing 12.07(A)(2)(f).

¹⁵See American Psychiatric Association, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* 458 (4th ed. 1994) (hereinafter "DSM-IV").

¹⁶Readers unfamiliar with medical terminology will be comforted with the knowledge that the discussion, though technical, will be rewarding. For clarity, we will begin with acute physical pain, as hereinafter more particularly described. It should be noted that related paresthesias (numbness, tingling) have a somewhat different physiology, and utilize different nerve pathways. See, generally, ADAMS, *supra* note 6, at ch 8. Consideration of other

II. Mostly Medicine

(a) Algology, The Study Of Pain.

Like every other conscious experience, the sensation of pain is perceived and interpreted in the brain. As one authority observes, pain "is a complex perceptual and affective experience determined by the unique past history of the individual, by the meaning to him of the injurious agent or situation, and by his 'state of mind' at the moment, as well as by the sensory nerve patterns evoked by physical stimulation."¹⁷ The brain's interpretation of the painful experience initiates various physiological and behavioral changes.¹⁸ Accordingly, in this section, as we discuss pain at the simple level of anatomy and physiology, it is well to keep in mind that we are omitting all of the relevant higher brain functions.

The anatomy of pain is straightforward, rather like wiring a door bell. Only two long neurons (nerve cells) are needed to transmit pain from the site of injury to the brain. One neuron extends from the pain receptor ("nociceptor"), located, typically, on the skin, to the spinal cord. This neuron is known as "afferent" because it transmits sensation to the center of the body,¹⁹ and "peripheral" to distinguish it from neurons in the spine, which are called "central."

Each peripheral neuron communicates with a central neuron by means of a chemical ("neurotransmitter") which has not been

symptoms (fatigue, syncope [fainting]) is deferred. Moreover, it should be kept in mind that, while minimal symptoms may be indicative of severe pathology, and that some life-threatening diseases, such as hypertension, may present no discernable symptoms, we are here concerned with situations in which pain is the predominant medical and functional problem. We will, of course, address the question whether little or no pathology can cause severe and lasting pain.

¹⁷Ronald Melzack, *Pain*, in OXFORD COMPANION TO THE MIND 574 (1987). See also Social Security Administration Commission on Pain, Report of the Commission on the Evaluation of Pain xii and 51, S.S.A. Pub. L. No. 64-031 (1987) (hereinafter "CMN. REP."); OSTERWEIS, *supra* note 8, at 13. Pain perception is obviously subjective; it cannot be objectively measured. OSTERWEIS, *supra* note 8, at 124. See also G. FISCHBACH, MIND AND BRAIN, A SCIENTIFIC AMERICAN SPECIAL REPORT (1994).

¹⁸ADAMS, *supra* note 6, at 103.

¹⁹As opposed to "efferent" nerves, which carry nerve impulses outward, toward the limbs.

conclusively identified.²⁰ A branch of the spinal neuron receives the pain message and carries it to the brain through a path in the spinal cord known as the spinothalamic tract.²¹ Fibers of this spinal neuron wind around fibers from other central neurons, so that the longest fibers (those from the base of the spine) come to lie on top, while fibers from progressively higher neurons occupy successively deeper positions. It would follow that partially severing the spinothalamic tract causes analgesia at successively higher levels, depending on the depth of the cut.²²

Fibers from the central neuron terminate in the brain stem or in the portion of the brain known as the thalamus. The thalamus plays a major, if unclear, role in pain sensation;²³ thalamic lesions are a known source of pain.²⁴ Medical texts describe the structure and compensation of nerve fibers in some detail.²⁵

Usually, pain arises from tissue damage, which activates nociceptors. "Three types of stimuli can activate pain receptors in peripheral tissues: mechanical (pressure, pinch), heat, and chemical. Mechanical and heat stimuli are usually brief, whereas chemical stimuli are usually long lasting."²⁶ However, "[t]he nociceptive nerve endings are so small that they are difficult to find, let alone study,"²⁷ and, as previously noted, "nothing is known about how [tissue damaging] stimuli activate nociceptors."²⁸ The process by which painful stimuli arouse nerve endings is called "transduction."²⁹

²⁰OSTERWEIS, *supra* note 8, at 131. At least as of 1987.

²¹ADAMS, *supra* note 6, at 102. "Crossing fibers are added to the inner side of the spinothalamic tract (the principal afferent pathway of the anterolateral fasciculus), so that the longest fibers from the sacral segment come to lie most superficially, and fibers from successively more rostral levels occupy a progressively deeper position. [Thus,] the depth to which the funiculus is cut will govern the level of analgesia that is achieved." *Id.* Lesions of a spinal neuron impair pain sensations permanently, whereas electrical stimulation produces pain. Pain arising in the head passes directly to the medulla oblongata.

²²*Id.*

²³*Id.* at 132.

²⁴MERCK at 1416; *see also* OSTERWEIS, *supra* note 8, at 132; ADAMS, *supra* note 6, at 105.

²⁵*See, e.g.,* ADAMS, *supra* note 6, at 103 n.1.

²⁶OSTERWEIS, *supra* note 8, at 124-25.

²⁷*Id.* at 125.

²⁸*Id.*

²⁹*Id.* at 124.

There are measurable chemical changes associated with transduction.³⁰ However,

"[e]ven when there is demonstrable degeneration of the spine and compression of a nerve root -- a condition generally acknowledged to be extremely painful -- it is not known what it is about the condition that actually causes pain.... Much research and clinical experience with pain have demonstrated that there is no clear relation between the amount of tissue damage and the degree of discomfort or functional disability.... Although it is possible to identify neural activity that ordinarily causes pain, there can also be pain without any neural activity; conversely, there can be activity in the primary afferent nociceptors without pain."³¹

So far, we have been discussing the fact that damage to bodily tissue (skin, muscles) activates pain receptors. By contrast, "[t]raumatic injury to a peripheral nerve is rarely painful, but when it is, it may be dramatically so. Causalgia (heat pain) is an example...."³² Diabetes mellitus, alcohol toxicity, and other diseases that affect peripheral nerves are frequently associated with pain.³³

Pain resulting from damage to the peripheral nerves is known as neuropathetic pain. Those affected include "[p]atients with relatively minor injuries [who] occasionally develop pain disproportionate to their injuries.... In some of these patients... selective blockade of the [pain

³⁰*Id.*

³¹*Id.* at 2-4.

³²OSTERWEIS, *supra* note 8, at 139.

³³*Id.*

pathway] produces immediate and dramatic relief."³⁴ This latter condition, which may lead to permanent impairment, is called "reflex sympathetic dystrophy."³⁵

Another important process is "sensitization": "[w]ith repeated stimuli, the thresholds of primary afferent nociceptors progressively decrease, so that normally innocuous stimuli become painful,"³⁶ as in the case of touching sunburned skin.

We now arrive at the phenomenon of "referred pain." Astonishingly, notwithstanding our description of peripheral afferent neurons, there does not always appear to be a direct path from the site of injury to the spinal cord. Thus, according to the IOM,³⁷ "when the damage to deep tissues is severe or long lasting, the sensation it produces may be misperceived as arising from a site that is distant from the actual site of damage."³⁸ The mechanism of referred pain is "unknown for any particular case."³⁹

There has been much speculation about the mechanics of referred pain.⁴⁰ Two factual observations, however, may be in order. First, "[it] has been discovered that the sites of insertion of [Chinese acupuncture needles] correspond to myofascial 'trigger points'...."⁴¹ Myofascial pain syndrome and its relation to referred pain will be discussed later in this article. The second observation, which may or may not be relevant, is that rhizotomy (surgical interruption of the

³⁴OSTERWEIS, *supra* note 8, at 136. Neuropathetic pain (pain resulting from damage to the peripheral nerves themselves) is associated with a variety of syndromes, perhaps including phantom limb pain. The pathogeneses of these syndromes is "obscure," but they are frequently grouped under two headings: "sympathetic-mediated pains," which are dependent on efferent sympathetic activity [efferent = away from the center, toward the limb], and "deafferentation pains," in which there is a partial or complete interruption of peripheral or central afferent neural activity.

³⁵*Id.* at 137; *see also* M.S. Friedman, *Reflex Sympathetic Dystrophy and Sympathetically Maintained Pain* (unpublished); J. A. Evans, *Reflex Sympathetic Dystrophy*, 26 ANN. INTERN. MED. 417-26 (1947).

³⁶OSTERWEIS, *supra* note 8, at 136.

³⁷*Id.* at 129.

³⁸citations omitted.

³⁹*Id.*

⁴⁰*Id.* at 130; *see also* ADAMS, *supra* note 6, at 107.

⁴¹Ronald Melzack, *Pain*, in OXFORD COMPANION TO THE MIND 574 (1987).

'pain pathway') is now uncommon because it "so frequently ended in failure."⁴²

The body's natural defense to pain is known as "modulation."⁴³ As we know, more often than not, pain is self-limiting. As Epicurus observed,⁴⁴ circa 300 B.C., "pain has this most excellent quality: if prolonged it cannot be severe, and if severe it cannot be prolonged."

A neuronal pathway for spontaneous analgesia has been suggested by experiments involving the electrical stimulation of the brains of animals: the network may run from the mid brain to the medulla and then to the spinal cord.⁴⁵ Endogenous opioid peptides, chemicals similar in structure to opium, have been discovered in nerve tissue, and may play a role in pain suppression.⁴⁶ Clinical studies suggest that endorphin-mediated analgesia is activated after surgery and can have a significant effect in reducing pain.⁴⁷ Finally (for our purposes) serotonin and norepinephrine, neurotransmitters involved in clinical depression, may indirectly bear on pain modulation.⁴⁸

Although analgesic drugs have been known since very ancient times,⁴⁹ their use in the regular course of medicine and surgery eluded the imagination of most practitioners until the middle of the Nineteenth Century;⁵⁰ even today, they are dramatically underutilized in some

⁴²*Id.* The relevance of this observation, with respect to referred pain, is, however, pure speculation (on my part). Cf. ADAMS, *supra* note 6, at 99, 108.

⁴³OSTERWEIS, *supra* note 8, at 134.

⁴⁴As paraphrased by Seneca. J. Bede and H. Simon, *Evaluating Pain in the Ninth Circuit*, 2 O.H.A. L. J. 33 (1991).

⁴⁵*Id.* at 135; see also ADAMS, *supra* note 6, at 105.

⁴⁶*Id.*; see also ADAMS, *supra* note 6, at 105.

⁴⁷*Id.*; see also ADAMS, *supra* note 6, at 105.

⁴⁸*Id.* at 172.

⁴⁹R. Millman, *The Opiates*, in TEXTBOOK OF MEDICINE 586 (Beeson-McDermott 1975). It has been observed that the seed pods of the lotus plant, eaten by Odysseus' men in Homer's epic, resemble the seed pods of the opium poppy. NEW CENTURY CLASSICAL HANDBOOK 648 (1962). "Paracelsus' laudanum ... was generally, at least, a preparation of opium, sometimes opium itself." A. C. WOOTON, II CHRONICLES OF PHARMACY 243 (1994).

⁵⁰See A. C. WOOTON, II CHRONICLES OF PHARMACY 249 (1994). In 1680, Sir Thomas Sydenham, the famous British physician, wrote "[a]mong the remedies which it has pleased Almighty God to give man to relieve his sufferings, none is so universal and efficacious as opium. Ronald Melzack, *Pain*, in OXFORD COMPANION TO THE MIND 574 (1987).

cases.⁵¹ However, opium and its derivatives (principally morphine) remain among the most effective drugs for severe, acute pain.⁵² The side-effects of these powerful narcotics (notably tolerance and the potential for addiction) limit their utility in cases of minor pain and chronic pain.⁵³ Aspirin and other non-steroidal anti-inflammatory drugs are thought to achieve analgesia by inhibiting the biosynthesis of a chemical known as prostaglandin.⁵⁴

Sometimes, of course, acute pain does not resolve, or does not completely resolve, especially (perhaps) when it is associated with ongoing determinable pathology (e.g., arthritis). As we shift our attention to cases in which complaints of pain arise or persist in the absence of a known causative agent, we are obliged to step back and take a broader look at the subjective experience of pain.

(b) The Experience of Pain

"This concept of a distinct, medically identifiable impairment with individual anatomical, physiological, or psychological makeup and totally independent of social, economic or geographic context is at the root of the current problem with cases that turn principally on the applicant's pain."⁵⁵

⁵¹I am thinking of the modern reluctance of some practitioners to use narcotics even in cases of terminal cancer pain. Cf. HARRISON'S PRINCIPLES OF INTERNAL MEDICINE 52 (Kurt J. Isselbacher et al. eds., 13th ed. 1994) (hereinafter "HARRISON"). Also, "[w]hen no medical, neurologic, or psychiatric disease can be established, we are convinced that it is usually better to let the patient suffer than to prescribe opiates or subject the patient to ablative surgery." ADAMS, *supra* note 6, at 111. "For major surgery in newborn infants, 97 (91%) anaesthetists prescribed systemic opioids in 1995 as compared with six (10%) in 1988." J. De Lima et al., *Infant and Neonatal Pain*, BRIT. MED. J. 787 (1996).

⁵²OSTERWEIS, *supra* note 8, at 135.

⁵³*Id.* at 203.

⁵⁴CURRENT MEDICAL DIAGNOSIS AND TREATMENT 10 (L. M. Tierney et al. eds., 33rd ed. 1994) (hereinafter "CUR. DX. & TR. "). A prostaglandin is "[o]ne of a group of fatty acids that is naturally in the body and that acts in a similar way to hormones." American Medical Association, *ENCYCLOPEDIA OF MEDICINE* 824 (Charles B. Clayman ed., 1989).

⁵⁵OSTERWEIS, *supra* note 8, at 27.

We began the section on algology with a definition of pain; it is now useful to distinguish pain from suffering, an independent emotional state.⁵⁶ There can be pain without suffering⁵⁷ and vice versa.⁵⁸ Moreover "tolerance" for pain should be distinguished from pain "thresholds." For example, when heat is applied to the skin, most people report the onset of pain between 43 and 46 degrees C.⁵⁹ "In contrast to this relatively reproducible pain-detection threshold, tolerance for pain differs widely among individuals."⁶⁰

Numerous studies have attempted to distinguish pain tolerance on the basis of genetic and anthropological factors,⁶¹ ethnicity,⁶² age,⁶³ sex,⁶⁴ family,⁶⁵ and personality.⁶⁶ While some of these studies reveal intriguing variations, their utility in disability evaluation is negligible.

Differences in pain behavior (for example, histrionics vs. stoicism),⁶⁷ where the emphasis is more on the manner of expressing pain than on the actual level of tolerance, are more important at the fact finding stage of adjudication. For example, "[i]n non-Western societies and among traditionally oriented ethnic groups, there tends to be an emphasis primarily on bodily complaints (headaches, fatigue, dizziness for example), and psychological symptoms are less frequent."⁶⁸ Education and verbal intelligence are obvious factors to be

⁵⁶*Id.* at 150.

⁵⁷*Id.* Cf. M. Afilalo & C. Tselios, *Pain Relief Versus Patient Satisfaction*, 27 ANN. EMERG. MED. 436-38 (1996).

⁵⁸In this context it is sometimes said that, for a criminal under sentence of death, execution is not the punishment; it terminates the punishment.

⁵⁹OSTERWEIS, *supra* note 8, at 133; *see also* ADAMS, *supra* note 6, at 105.

⁶⁰ADAMS, *supra* note 6, at 105.

⁶¹OSTERWEIS, *supra* note 8, at 157.

⁶²Knox H. Todd, *Pain Assessment and Ethnicity*, 27 ANN. EMERG. MED. 421-23 (1996).

⁶³T. E. Terndrup, *Pediatric Pain Control*, 27 ANN. EMERG. MED. 466-70 (1996).

⁶⁴K. Nevin, *Influence of Sex on Pain Assessment and Management*, 27 ANN. EMERG. MED. 424-26 (1996).

⁶⁵OSTERWEIS, *supra* note 8, at 156.

⁶⁶*Id.* at 154; *see also* ADAMS, *supra* note 6, at 108.

⁶⁷HARRISON, *supra* note 51, at 65.

⁶⁸Kleinman & A. Cohen, *Psychiatry's Global Challenge*, SCIENTIFIC AMERICAN, March 1997, at 8. Regarding pathoplastic variations generally, *see* OSTERWEIS, *supra* note 8, at 158. *See also* ADAMS, *supra* note 6, at 105.

considered. "Alexithymia" is the medical term for inability to express one's emotions; it is a recognized pathological state.⁶⁹

It is common experience that activity, time, and circumstances affect our perception and tolerance for pain. Emotional stress causes muscle contractions which may contribute to nerve impingement.⁷⁰ On the other hand, distraction therapy is well known to women participating in natural childbirth classes. Athletes and soldiers may be oblivious to significant injuries at the time they arise.⁷¹ On the other hand, the expectation of pain has been known to induce pain without a noxious stimulus.⁷² "Thinking about sex can cut pain in half, according to a Johns Hopkins study," reported in *Playboy*. "Two groups held their hands in ice water for as long as they could tolerate the cold. Those told to think about sex kept their hands in twice as long as those told to think about abstinence."⁷³ Finally, while "[w]e know that if a stimulus to perception persists continually, like the ticking of a clock, the noise of traffic, a strong odor, we become accustomed to it and we cease to be aware of it,"⁷⁴ "pain does not appear to be subject to negative adaptation;"⁷⁵ indeed, "the sensory experience may outlast the stimulus."⁷⁶

Full consideration of pain behavior requires discussion of symptom perception; meaning attribution, expression and communication; help-seeking behavior; and other coping responses.⁷⁷ There are circumstances which reinforce pain behaviors, and others which help to extinguish them.⁷⁸ Critical as these factors may be to therapy and rehabilitation, and determinative as they may sometimes be in disability adjudication, we can only mention them here.

⁶⁹AMERICAN PSYCHIATRIC GLOSSARY 10 (Evelyn M. Stone ed., 1988).

⁷⁰OSTERWEIS, *supra* note 8, at 3.

⁷¹*Cf.* OSTERWEIS, *supra* note 8, at 135; ADAMS, *supra* note 6, at 105; HARRISON, *supra* note 51 at 51.

⁷²HARRISON, *supra* note 51, at 51.

⁷³PLAYBOY, April 1997, at 32; *see also* OSTERWEIS, *supra* note 8, at 133.

⁷⁴*Cf.* G. BOAS, THE HISTORY OF IDEAS 52-53 (1969).

⁷⁵ADAMS, *supra* note 6, at 108.

⁷⁶*Id.*

⁷⁷OSTERWEIS, *supra* note 8, at 148-52.

⁷⁸W. E. Fordyce, *Chronic Pain*, in HANDBOOK OF SEVERE DISABILITY 222 (Stolov & Clowers., eds., 1981).

More to the point, perhaps, the Commission on the Evaluation of Pain (a predecessor to the IOM, discussed *infra*), concluded⁷⁹ that persons with a degree of pain approaching a level consistent with a claim of disability tend to demonstrate the following five behaviors: (i) preoccupation with the pain, (ii) over utilization of the health care system, (iii) inappropriate use of analgesic and/or depressant (sic) drugs, (iv) reduced levels of activities and avoidance of responsibility,⁸⁰ (v) motor activity: rubbing the painful area, grimacing, guarding, bracing.

Compliance with prescribed treatment is, of course, required of applicants for Social Security disability benefits;⁸¹ treatment modalities for chronic pain are described later in this article. Recognizing, however, that we live in an imperfect world, the AMA Guides to the Evaluation of Permanent Impairment⁸² remind us that:

"Maladaptive pain behavior frequently includes prolonged periods of inactivity and immobilization. This, in turn, results in deconditioning, joint contractures, postural imbalances, musculoskeletal deterioration [,] neuromuscular dystrophy [and a biological feedback loop]."

It follows that, iatrogenesis aside, subjective symptoms can lead to objective findings.

(c) Hard Cases

"[A]t least 10% of all medical - surgical patients have no objective evidence of disease."⁸³

⁷⁹Social Security Administration, Report of the Commission on the Evaluation of Pain, at 82-83, PB87-183497 (June 20, 1986) [hereinafter CMN. REP.] CMN. REP. at 82-83.

⁸⁰OSTERWEIS, *supra* note 8, at 245. Regarding compensation as a possible disincentive to work.

⁸¹With exceptions: *see* 20 C.F.R. §§ 404.1530, 416.930 (1991).

⁸²AMERICAN MEDICAL ASSOCIATION, GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT 248 (3rd rev. ed. 1990) (hereinafter "AMA GUIDES").

⁸³C. V. Ford, *Illness as a Lifestyle*, 17 SPINE S338 (1992).

"The absence of a diagnosable disease does not mean the absence of abnormalities, disturbances, or alterations in bodily functions. Thus, severe illness, illness behavior, and suffering can exist in the absence of a diagnosable disease."⁸⁴

The "hard cases" confronting Administrative Law Judges are those involving symptoms in excess of findings, symptoms without objective findings and idiosyncratic symptoms. On the one hand, there are many diseases of unknown etiology which may be characterized by potentially limiting significant symptoms; systemic lupus erythematosus and other suspected auto-immune diseases are obvious examples.⁸⁵ Allodynia (pain from a non-noxious stimulus) and hyperpathia (particularly unpleasant, exaggerated pain response)⁸⁶ are, perhaps, more often seen by Administrative Law Judges than by physicians. Chronic pain, on the other hand (defined as pain persisting more than three to six months)⁸⁷ is the important phenomenon with which we are here most concerned.

(1) Back Pain

The body part most frequently affected is the back: According to the Commission on the Evaluation of Pain, almost two thirds of all chronic pain syndrome (CPS) cases and almost one third of all other pain cases involve the back.⁸⁸ However, as we have seen, "very little is known about the mechanism [of] low back pain."⁸⁹ Fortunately, fewer than 10% of people with acute back pain develop disabling chronic pain,⁹⁰ and "acute low back pain (or acute exacerbations of

⁸⁴OSTERWEIS, *supra* note 8, at 152-53.

⁸⁵See, e.g., MERCK, *supra* n. 24. And, of course, there are life-threatening impairments (e.g., hypertension) which may give rise to no pain or other sensation whatever.

⁸⁶MERCK, *supra* n. 24, at 1417.

⁸⁷MERCK, *supra* n. 24, at 1407.

⁸⁸CMN. REP. *supra* n. 9, at 15.

⁸⁹OSTERWEIS, *supra* note 8, at 2. *Id.* at 112, 126.

⁹⁰*Id.* at 206.

chronic low back pain) usually remit in two weeks regardless of the mode of treatment."⁹¹

(2) Headaches

Headaches (cephalgia), of course, are an exceedingly common symptom for which there are many known causes, some extremely morbid, most relatively benign.⁹² The differential diagnosis requires a detailed description of the pain, as well as a careful history, physical and neurological examination, and, in some cases, appropriate imaging.⁹³ While a physician will rule out such causes as tumors and infections, there is a large class of cases which are usually described on the basis of symptoms, and about which very little is known.⁹⁴ The headaches noted in the following paragraph generally fit this description.

Garden variety tension headaches are usually generalized, most intense about the neck or back of head, and are not associated with focal neurologic symptoms. They may be constant, daily, and accompanied by other vague symptoms.⁹⁵ By contrast, vascular headaches (migraines) are lateralized or generalized, dull or throbbing, sometimes with anorexia, nausea, vomiting, photophobia and blurring of vision.⁹⁶ "The most important datum ... is whether the headache throbs with each arterial pulse, indicating a vascular origin."⁹⁷ Luminous visual hallucinations are common; there may be other focal disturbances. Migraines tend to build up gradually and last for several hours or more. Treatment often consists of rest in a dark quiet room, aspirin, or Cafegot. Prophylactic treatment (e.g., Propranolol) may last

⁹¹*Idat* 194. "Approximately 80% of patients with acute low back pain experience improvement within two weeks of onset [R]esolution usually occurs without intervention...." M. Brody, *Low Back Pain*, 27 ANN. EMERG. MED. 454-58 (1996).

⁹²MERCK, *supra* n. 24, at 1422.; *see also* N. H. Raskin, *Headache*, in MERRITT'S TEXTBOOK OF NEUROLOGY 42 n.1 (9th ed. 1995) (hereinafter "MERRITT"); ADAMS, *supra* note 6, at 129 n. 1.; Headache, A Harvard Health Letter Special Report (1992).

⁹³MERCK, *supra* n.24, at 1422.

⁹⁴*Id.* at 1425; *see also* K. Furgerson, *Considering Headache Pain in the Disability Evaluation*, 1 O.H.A. L. J. 43 (1990).

⁹⁵CUR. DX. & TR., *supra* note 54, at 798 n.1.

⁹⁶*Id.*

⁹⁷ADAMS, *supra* note 6, at 133.

for months with, however, significant side effects.⁹⁸ Other familiar types of headache include cluster headaches (which usually affect middle aged men and consist of severe, unilateral periorbital pain, recurring each night for several weeks), depression headaches, and post traumatic headaches.⁹⁹

Some researchers believe "that headaches are not distinct entities and may represent a continuum from tension headache to migraine."¹⁰⁰ In one study,¹⁰¹ "headache occurred only rarely during work hours but generally left the subject disabled.... The disability caused by headache was most frequently partial and caused a total abstention from activity in only 2.6% of cases.... These results are in agreement with [another study which] found that 50% of migraineurs had to discontinue activities during their headache attacks (one-third required bed rest) while only one-fourth of patients with tension type headaches had to discontinue their usual activities.... Therefore, [patients with episodic headaches and those with both migraines and tension headaches] appear to be characterized by a higher degree of work and social handicap,.... while [patients with chronic tension type headaches] seem to be characterized by higher health care resource use (and costs).... [Moreover] it is most common for migraineurs to have less than one attack a month."

⁹⁸CURDX. & TR. at 678 n.l. Sumatriptan is a promising new therapy for migraines. Headache, Harvard Health Letter Special Report 26 (3rd printing, July 1995).

⁹⁹*Id.* "Lance has recently described 21 cases of [headaches related to sexual activity], predominantly in males." ADAMS, *supra* note 6, at 141 (emphasis added).

¹⁰⁰J. Spence, *Migraine and Other Causes of Headache*, 27 ANN. EMERG. MED. 449 (1996) (citations omitted); see also MERRITT, *supra* note 92 at 42.

¹⁰¹G. Micieli et al., *Quantification of Headache Disability*, 35 Headache 131-37 (1995).

(3) Fibromyalgia

"Fibrositis (also called fibromyalgia) is one of the most common rheumatic syndromes in ambulatory general medicine."¹⁰² It is also one of the most controversial. Some authorities, assuming the existence of a discreet impairment, recommend a precise diagnostic protocol (described below). Others¹⁰³ refer to it as a "wastebasket diagnosis" or the syndrome of "irritable everything."

Although Current Diagnosis and Treatment¹⁰⁴ refers to the disease as "fibrositis," the Merck's Manual¹⁰⁵ prefers the name "fibromyalgia" on the grounds that the condition indicates pain ("-algia"), but no inflammation ("-itis") in fibrous tissues, muscles, tendons, ligaments, and other "white" connective tissues. According to Merck's, "Myofascial Pain Syndrome" and "Fibromyositis" are obsolete synonyms for this same group of "common nonarticular rheumatic disorders characterized by achy pain, tenderness and stiffness." These symptoms "may be primary and generalized or concomitant with another associated or underlying condition, or localized and often related to overuse or microtrauma factors."¹⁰⁶ Competing definitions, which may or may not describe the same pathological process, are also remarkable for their lack of specificity.¹⁰⁷

David G. Simons, M.D., the author of a minority report to the IOM¹⁰⁸ argued for the existence of three different impairments. Simons acknowledged that "... some [clinicians] express strong doubts about

¹⁰²CUR. DX. & TR., *supra* note 54, at 678. Circuit Court cases dealing with this impairment include: *Rivera-Figueroa v. Secretary of Health & Human Serv.*, 858 F.2d 48 (1st Cir. 1988); *Lisa v. Secretary of Health & Human Serv.*, 940 F.2d 40 (2nd Cir. 1990); *Chrupcala v. Heckler*, 829 F.2d 1269 (3rd Cir. 1987); *Preston v. Secretary of Health & Human Serv.*, 854 F.2d 815 (6th Cir. 1988); *Cline v. Sullivan*, 939 F.2d. 560 (8th Cir. 1991).

¹⁰³See e.g., R. Bennett, *Recognizing Fibromyalgia*, PATIENT CARE, July 15, 1989, at 62-63; cf. D. Goldenberg, *Fibromyalgia Syndrome*, 257 JAMA 2782 (1987).

¹⁰⁴CUR. DX. & TR., *supra* note 54, at 678.

¹⁰⁵MERCK, *supra* note 24 at 1369-70.

¹⁰⁶*Id.*

¹⁰⁷See e.g., M. B. Yunus, *Fibromyalgia Syndrome*, 36 CONSULTANT 1260 (1996); cf. OSTERWEIS, *supra* note 8, at 200.

¹⁰⁸"Myofascial Pain Syndromes Due to Trigger Points"; see also OSTERWEIS, *supra* note 8, at 285.

the existence of myofascial trigger points."¹⁰⁹ However he contended that "[m]yofascial trigger points are one of three musculoskeletal dysfunctions that are commonly overlooked.... The other two are fibromyalgia or fibrositis, and articular dysfunction. None has a diagnostic laboratory or imaging test at this time. All three conditions presently require diagnosis by history and physical examination alone. In each case, the diagnosis would probably be missed on routine conventional examination. The examiner must know precisely what to look for, how to look for it, and then must actually be looking for it."¹¹⁰

With all appropriate regard for Dr. Simons' level of confidence, a lawyer might be inclined to observe that a person who believes in a will-o'-the-wisp, and is looking for one, is more likely to find one than a doubter.¹¹¹ In any event, as the foregoing discussion makes clear, if any of these impairments exist, virtually nothing about them is known with any degree of certainty.

The term "trigger points," as used by Dr. Simons, refers to the phenomenon of referred pain. As stated by the majority of the IOM committee, "irritable spots, such as myofascial trigger points in skeletal muscles, also cause feelings of pain in locations distant from the irritable spot."¹¹² Dr. Simons' criteria for the trigger point syndromes require, in addition to referred pain, tenderness at the trigger point, hardening of a taught band of muscle fibers passing through the tender spot, a local twitch response, and a history involving the foreshortening of affected muscles.¹¹³

In 1990, the American College of Rheumatology (ACR) developed two primary criteria that (hopefully) would distinguish fibromyalgia from other musculoskeletal disorders and serve as a basis for research:¹¹⁴

¹⁰⁹OSTERWEIS, *supra* note 8, at 198.

¹¹⁰*Id.* at 285, 138.

¹¹¹As I write, the most recent example that comes to mind is J. Gibeaut, *Confidence Boost*, 83 A.B.A. J. 26 (1997).

¹¹²OSTERWEIS, *supra* note 8, at 130. Dr. Simons cited a study in which "pain was referred to remote locations from muscles throughout the body in response to intramuscular injections of hypertonic saline." *Id.* at 286.

¹¹³OSTERWEIS, *supra* note 8, at 288.

¹¹⁴F. Wolfe et al., *Report, Arthritis Rheum 1990*, cited in T. W. Starz et al., *Putting the Finger On Fibromyalgia: The Manual Tender Point Study*, J. MUSCULOSKELETAL MED. 61 n.2 (1997). According to CUR. DX. & TR., *supra* note 54, the disorder should not be a

"(1) Three or more months of wide spread pain, defined as pain present above and below the waist on the right and left sides of the body and along the midline, and (2) demonstration of tenderness in at least 11 of 18 specified locations throughout the body when palpated with approximately 4 kg [10 lbs.] of digital pressure."¹¹⁵ "Although these criteria were first developed for research purposes, they are widely used by clinicians in diagnosing fibromyalgia[.]"¹¹⁶

The ACR criteria rely upon site tenderness, rather than referred pain. An examination protocol advocated by T. Starz, M.D., and others¹¹⁷ consists of manual palpation of three control locations (middle of the forehead, right forearm, and left thumb) and 18 survey spots (one on each side of the body at the following nine locations): base of the skull (occiput at the nuchal ridge), trapezius (muscle between neck and shoulder), supraspinatus (near scapula), gluteal (hip), low cervical, second rib (front), lateral epicondyle (elbow), greater trochanter (upper thigh) and knee. The patient rates the severity of the pain at each location.

Treatment (to which we will return) consists of "supportive measures, such as reassurance and explanation of the benign nature of the syndrome, as well as stretching exercises, improved sleep, local applications of heat, gentle massage" aspirin and amitriptyline (Elavil), an antidepressant.¹¹⁸ The condition "may remit spontaneously (in milder cases) with decreased stress,"¹¹⁹ [f]unctional prognosis is usually favorable with a comprehensive, supportive program, although some

diagnosis of exclusion.

¹¹⁵T. W. Starz et al. *Putting the Finger On Fibromyalgia: The Manual Tender Point Study*, J. MUSCULOSKELETAL MED. 61 (1997).

¹¹⁶*Id.*

¹¹⁷*Id.*

¹¹⁸MERCK, *supra* note 24, at 1370.

¹¹⁹*Id.*

degree of symptoms tends to persist."¹²⁰ Finally, "[compared to Chronic Fatigue Syndrome, the federal courts] have not been as willing to accept [fibromyalgia] as disabling, especially since many physicians prescribe increased activity as treatment."¹²¹

(4) Somatoform Pain Disorder

In view of Social Security's long standing preference for objective findings in pain cases (see *infra*), it is ironic that the Administration rejected a pain listing that would have required tissue damage or similar pathology, and adopted a listing which imposes no such requirement.

The proposal was made in 1986 by a minority of the Commission on the Evaluation of Pain.¹²² Its proposed "Listing 14.00: Impairment Due Primarily to Pain"¹²³ would have required "measurable impairment of function with physical tissue damage in body parts specifically related to the complaints of pain; OR pain complaints apparently disproportionate and/or inappropriate in location, intensity or duration to the physical damage and/or its expected healing time" AND behavioral manifestations including three out of five criteria (preoccupation with pain, over utilization of the health care system, excessive use of analgesics, body language expressive of pain, other pain behaviors) AND various marked functional limitations. A majority of the Commission, however, found "insufficient data for such a recommendation."¹²⁴

Even more pointedly, the Institute of Medicine concluded in 1987¹²⁵ that "[n]either 'chronic pain syndrome' nor illness behavior should be added to the regulatory listing of impairments. Although the committee acknowledges the value of these terms in certain contexts, they should not be used for SSA disability purposes. There has been no demonstration of a common etiology, a predictable natural history, a

¹²⁰*Id.* at 1371.

¹²¹18 SOCIAL SECURITY FORUM 19 (1996). Cf. *Sarchet v. Chater*, 78 F.3d 305, 306-7 (7th Cir. 1996).

¹²²CMN. REP. *supra* note 79, at 127.

¹²³*Id.* at 125 n.l.

¹²⁴*Id.* at 15.

¹²⁵OSTERWEIS, *supra* note 8, at 8; *Id.* at 267.

clearly defined constellation of symptoms, or a specific treatment for the various pain conditions that would suggest a basis for positing a single chronic pain syndrome." That apparently settled the matter, insofar as SSA was concerned.

Previously, in 1985, the Administration adopted final regulations amending its criteria for mental disorders.¹²⁶ At that time the Administration expressly deferred inclusion of "pain" as a criterion, but, in Listing 12.07 (somatoform disorders), included criteria that seem applicable to psychogenic pain.

The language of Listing 12.07 has not changed since it was promulgated. It defines somatoform disorders as "physical symptoms for which there are no demonstrable organic findings or known physiological mechanisms" (emphasis added). Consistent with that definition, the Listing¹²⁷ recognizes "persistent nonorganic disturbance" of "sensation (e.g. diminished or heightened)" as potentially disabling. Thus, the Listing recognizes "heightened sensation" for which there is no organic basis, (which almost certainly¹²⁸ includes pain, a common condition, as well as hyperalgesia, an uncommon one) while ignoring pain cases in which some organic pathology can be identified.

Compounding the irony is the fact that the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (3rd ed., 1980) ("DSM-III"), which the Social Security Administration considered authoritative, recognized as Psychogenic Pain Disorders both cases in which there was "no organic pathology" and cases "where there is some related organic pathology [but] the complaint of pain is grossly in excess of what would be expected from the physical findings."¹²⁹ This distinction was carried over when the DSM was

¹²⁶Listing of Impairments--Mental Disorders, 50 Fed. Reg. 35038 (Aug. 20, 1985).

¹²⁷20 C.F.R. Pt. 220, App. 1, listing 12.07(A)(2)(f).

¹²⁸A number of circuit courts have implicitly assumed, or expressly held, that somatoform pain disorder is a basis for Social Security disability. *See, e.g.,* Latham v. Shalala, 36 F.3d 482, 484 (5th Cir. 1994); Blankenship v. Bowen, 874 F.2d 1116, 1123 (6th Cir. 1989); Cass v. Shalala, 8 F.3d 552 (7th Cir. 1993); Easter v. Bowen, 867 F.2d 1128 (8th Cir. 1989); Pratt v. Sullivan, 956 F.2d 830, 834 (8th Cir. 1992). *Cf.* Soc. Sec. Ruling 96-6p. I am aware of no published decision holding the contrary.

¹²⁹*See* American Psychiatric Association, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 249 (3rd ed.) (hereinafter "DSM-III-R"). "A. Severe and prolonged pain is the predominant disturbance. B. The pain presented as a symptom is inconsistent with the anatomic distribution of the nervous system; after extensive evaluation, no organic

revised in 1987;¹³⁰ in DSM-IV (1994), separate diagnostic codes were adopted to formalize the difference.¹³¹

It may be helpful, in the context of the present discussion, to review the diagnostic features of Pain Disorder as described in DSM-IV.¹³²

"The essential feature of pain disorder is pain that is the predominant focus of the clinical presentation and is of sufficient severity to warrant clinical attention. ... The pain causes significant distress or impairment in social, occupational, or other important areas of functioning.... Psychological factors are judged to play a significant role in the onset, severity, exacerbation, or

pathology or pathophysiological mechanism can be found to account for the pain; or, when there is some related organic pathology, the complaint of pain is grossly in excess of what would be expected from the physical findings. C. Psychological factors are judged to be etiologically involved in the pain, as evidenced by at least one of the following: (1) a temporal relationship between an environmental stimulus that is apparently related to a psychological conflict or need and the initiation or exacerbation of the pain (2) the pain's enabling the individual to avoid some activity that is noxious to him or her (3) the pains' enabling the individual to get support from the environment that otherwise might not be forthcoming. D. Not due to another mental disorder." *Id.*

¹³⁰In DSM-III-R the criteria for Somatoform Pain Disorder are: "A. Preoccupation with pain for at least six months. B. Either (1) or (2): (1) appropriate evaluation uncovers no organic pathology or pathophysiologic mechanism (e.g., a physical disorder or the effects of injury) to account for the pain (2) when there is related organic pathology, the complaint of pain or resulting social or occupational impairment is grossly in excess of what would be expected from the physical findings." *Id.* See also *Easter v. Bowen*, 867 F.2d. 1128 (8th Cir. 1989).

¹³¹In DSM-IV, 307.80 is the code for disorders in which "psychological factors are judged to have the major role in the onset, severity, exacerbation, or maintenance of the pain," and 307.89 is the code when "both psychological factors and a general medical condition are judged to have important roles [in onset, severity, etc.]" DSM-IV at 458. According to DSM-IV, the conditions are acute if they last for less than six months, chronic if they have a duration of six months or longer. *Id.* at 459. Pain caused by a general medical condition, in which psychological factors play only a minor role, is not recognized as a psychiatric impairment in DSM-IV.

¹³²*Id.* at 458.

maintenance of the pain. ... The pain is not intentionally produced or feigned as in Factitious Disorder¹³³ or Malingering [discussed infra]. ... Pain Disorder is not diagnosed if the pain is better accounted for by a Mood, Anxiety, or Psychotic Disorder, or if the pain presentation meets criteria for Dyspareunia [pain during sexual intercourse]. Examples of impairment resulting from the pain include inability to work or attend school, frequent use of the health care system, the pain becoming a major focus of the individual's life, substantial use of medications, and relational problems such as marital discord and disruption of the family's normal lifestyle."¹³⁴

Among the associated features identified by DSM-IV are unemployment, disability, family problems, drug dependence, suicide, persistent search for an unobtainable cure, inactivity, social isolation, depression, fatigue, and more pain.¹³⁵ DSM-III-R listed as an associated feature: "[t]he person usually refuses to consider the contribution of psychological factors to the pain."¹³⁶

Finally, of course, "[i]t is not unusual for patients with endogenous depression to have pain as the predominant symptom. And most patients with chronic pain of all types are depressed."¹³⁷

¹³³Factitious Disorders: while the motivation is unconscious, the production of signs and symptoms is conscious. The conscious behavior may be extreme (e.g., intentionally blinding oneself). This behavior is motivated by primary (internal or psychological) gain. S. Eisendrath, *When Munchausen Becomes Malingering: Factitious Disorders That Penetrate the Legal System*, 24 BULL. AM. ACAD. PSYCHIATRY. L. 471 (1996). "It is a rare cause of chronic pain." OSTERWEIS, *supra* note 8, at 171.

¹³⁴DSM-IV continues: "The psychological factors involved may consist of another Axis I or Axis II disorder (which would also be diagnosed) or may be of a nature that does not reach the threshold for such a disorder (e.g., reactions to psychosocial stressors)." DSM-IV.

¹³⁵DSM-IV at 459.

¹³⁶DSM-III-R at 265.

¹³⁷ADAMS, *supra* note 6, at 110.

Are DSM and the Listing of Impairments talking about the same thing? To what extent is the DSM definition self referential, its reasoning circuitous? Without attempting to answer these questions, we note that the exclusive focus of the DSM is on defining a disorder. However, as the IOM observed: "In the absence of coexisting major depression, clinicians have found that pharmacological interventions and psychodynamic psychotherapies are often of little value in the treatment of somatization disorder."¹³⁸ We will return to the question of treatment.

(5) Chronic Pain Syndrome

The American Medical Association's Guides to the Evaluation of Permanent Impairment (3rd ed. Rev. 1990) are absolutely clear on this issue: "Chronic pain [which can lead to Chronic Pain Syndrome, sometimes also known as "Chronic Intractable Benign Pain Syndrome (CIBPS)"] must be considered a pathological disorder in its own right. It is chronic, long lived and progressive."¹³⁹ As we have seen, however, the IOM does not agree: "[c]hronic pain is not an entity but a physiological and psychosocial process."¹⁴⁰ As Judge Halligan pointed out in his thorough analysis, chronic pain syndrome is "a pain report or pain claim which cannot be explained well either by organic lesions or by causative mental disease, or by deliberate, dishonest feigning. The [Report of the Commission on the Evaluation of Pain] said such pain reports should never justify an award of benefits even if uncontradicted. [The regulation]¹⁴¹ adopts that policy."¹⁴²

¹³⁸OSTERWEIS, *supra* note 8, at 169.

¹³⁹AMA GUIDES, *supra* note 82, at 249. The AMA GUIDES distinguish Acute Recurrent Pain.

¹⁴⁰OSTERWEIS, *supra* note 8, at 146.

¹⁴¹20 C.F.R., *supra* note 82, §§ 404.1529, 416.929 (1991).

¹⁴²P. Halligan, *Credibility, Chronic Pain, and Converted Mental Conflict: Some Distinctions for Adjudicators* 38 SOC. SEC. REP. SERV. 793, 802 (1993).

(6) Malingering

As used in DSM-IV,¹⁴³ Malingering (code V65.2) is a term of art. The essential feature is "the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs. ... [I]t should be strongly suspected if any combination of the following is noted: (1) Medicolegal context of presentation (e.g., the person is referred by an attorney to the clinician for examination) (2) Marked discrepancy between the person's claimed stress or disability and the objective findings (3) Lack of cooperation during the diagnostic evaluation and in complying with the prescribed treatment regimen (4) The presence of Antisocial Personality Disorder."

The diagnosis expressly encompasses exaggeration and magnification of symptoms and what is sometimes termed "compensation neurosis."¹⁴⁴ The AMA Guides¹⁴⁵ confidently assert that "there is a consensus among algologists that malingering is readily detected with appropriate medical and psychological tests. It is an infrequent occurrence among the population of chronic pain patients." Unfortunately, the pain specialists (algologists) who comprise the "consensus" are not identified, the incidence of malingering is not quantified or documented, tests which "readily detect" this behavior are nowhere described in the Guides, and (with the exception of a few orthopedic procedures, discussed later in this article) the tests have evaded the research of the present writer. In fact, as the Institute of Medicine noted:¹⁴⁶ "there is virtually no systematic research on this topic."

¹⁴³DSM-IV at 683.

¹⁴⁴OSTERWEIS, *supra* note 8, at 249; *see also* P. Halligan, *Credibility, Chronic Pain, and Converted Mental Conflict: Some Distinctions for Adjudicators* 38 SOC. SEC. REP. SERV. 793, 809 n.1 (1993).

¹⁴⁵AMA GUIDES, *supra* note 82, at 258.

¹⁴⁶OSTERWEIS, *supra* note 8, at 171.

(d) Management Of Chronic Pain

In order to receive disability benefits, a claimant is generally required to follow prescribed treatment that can restore the ability to work.¹⁴⁷ However, a complete discussion of treatment for chronic pain is well beyond the scope of this article, in part because efforts at treatment have been many, while successful results have been few. The most common treatments for the most frequent complaint, low back pain, are appended to this article (Appendix I).

More generally, although the IOM sought to discourage the "proliferation of pain clinics or centers without first setting proper performance standards,"¹⁴⁸ it is both interesting and relevant to inquire what pain management clinics attempt to accomplish.¹⁴⁹

"[Pain centers] commonly use two general strategies for rehabilitating chronic pain patients. One approach reassures the patient that the pain will not harm them. Because most practitioners do not truly understand the pain's cause, efforts to convince the patient that the pain is harmless can be difficult and can strain the patient's credulity. The other approach encourages the patient to increase his or her activity and thus discover that this additional activity does not increase their pain."¹⁵⁰ Be that as it may, "a major focus [of rehabilitation medicine is] preventing secondary complications (physical, psychological, behavioral, or social) that lead to increased disability;"¹⁵¹ "often the first step ... is to wean patients from their multiple and high doses of drugs."¹⁵² Coping strategies, dealing with body part "overuse" syndrome, patient education in the form of behavioral modification, physical therapy and conditioning, and vocational rehabilitation, are components of some of the more successful pain control clinics.¹⁵³

Finally, as in all medical treatment, algologists must be alert to the dangers of iatrogenesis¹⁵⁴ and self-medication ("If I take more

¹⁴⁷20 C.F.R. §§ 404.1530, 416.930 (1991).

¹⁴⁸OSTERWEIS, *supra* note 8, at 236.

¹⁴⁹See CMN. REP., *supra* note 79, at 89 n.l.; HARRISON, *supra* note 51 at 53.

¹⁵⁰OSTERWEIS, *supra* note 8, at 236.

¹⁵¹*Id.* at 232.

¹⁵²*Id.* at 173.

¹⁵³*Id.* at 152, 236 n.l.

¹⁵⁴*Id.* at 202.

aspirin, perhaps it will stop the ringing in my ears.") As the IOM cautioned, "in a search for the pain's cause and for a way of relieving it, long rounds of tests, treatments, and referrals to specialists may ensue, often to no avail and sometimes compounding the problem."¹⁵⁵

III. Vocational Considerations

This broad topic (which might have been entitled Considerations Surrounding the Residual Functional Capacity, Employability, Accommodation, and Rehabilitation of Persons With Various Chronic Sensory-Related Subjective Limitations; or, Is there a job in the pre-school for M. de Tourette?), while central to the process of disability determination, can only be touched upon in the present article. Thus, the IOM emphasized that evaluation "should not be limited to medical evidence of an underlying disease process."¹⁵⁶ With or without medical findings, functional limitations should be considered. "This means not only assessing physical abilities such as sitting, standing, lifting, and walking, but also examining how the limitations imposed by pain affect aspects of the individual's daily life: sleeping, eating, self care, interpersonal relationships, the ability to concentrate and work activities."¹⁵⁷ While the current regulations¹⁵⁸ clearly require the presence of medical findings before a functional evaluation is undertaken, the balance of this quotation accurately reflects the present state of the law. The IOM might also have mentioned limitations imposed by medication and other pain treatment.

The Regulations acknowledge that pain results in both exertional and non-exertional limitations.¹⁵⁹ There are, indeed, at least five ways in which chronic pain can impact on an individual's ability to engage in the non-physical aspects of work: (1) "[P]ain is distracting"¹⁶⁰: It interferes with concentration, persistence and pace; (2) "[C]hronic pain

¹⁵⁵*Id.* at 13-14.

¹⁵⁶*Id.* at 269.

¹⁵⁷*Id.*

¹⁵⁸20 C.F.R. §§ 404.1529, 416.929 (1991)

¹⁵⁹*Id.* See also Soc. Sec. Ruling 96-4p (1996).

¹⁶⁰OSTERWEIS, *supra* note 8, at 149.

"[C]hronic pain patients are often depressed."¹⁶¹ They may also be irritable and grouchy: their social functioning may be impaired, and their ability to interact appropriately with supervisors, coworkers and members of the public may be reduced; (3) They may engage in guarding: "Chronic pain patients may be unnecessarily inactive because of fear of incurring additional body damage or pain." They withdraw from daily activities, including work;¹⁶² (4) Some may engage in rationalization: Other impairments more aversive to the individual than pain (e.g., memory loss, unsightly appearance, etc.) may be expressed as complaints of pain, with accompanying avoidance of social situations and the challenges of the work place;¹⁶³ (5) Finally, some may be motivated by prospects of secondary gain, particularly if they are unhappy or unsuccessful in low paying jobs which undermine their self-esteem.¹⁶⁴

Ergonomics (the study of conditions of the work place),¹⁶⁵ and a huge body of employment-related legislation (including, for example, the Americans With Disabilities Act)¹⁶⁶ present other issues which bear upon the question: What symptom-related limitations allow the performance of a significant number of jobs, and what limitations do not? Noting that "[t]he basic mental demands of competitive, remunerative, unskilled work include the abilities (on a sustained basis) to understand, carry out and remember simple instructions; to respond appropriately to supervision, coworkers and usual work situations; and to deal with changes in a routine work setting,"¹⁶⁷ and that vocational expert testimony is available to address complex cases, we can do little more than raise the question here.

¹⁶¹W. E. Fordyce, *Chronic Pain*, in HANDBOOK OF SEVERE DISABILITY, 223 (Stolov & Clowers eds., 1981); see also Alan Goldhammer & Susan Bloom, *Recent Changes in the Assessment of Pain in Disability Claims Before the Social Security Administration*, 3 SOC. SEC. REP. SERV. 1119 (1984).

¹⁶²*Id.*

¹⁶³*Id.*

¹⁶⁴*Id.*

¹⁶⁵CMN. REP., *supra* note 79, at 85.

¹⁶⁶42 U.S.C. § 12101 (1990).

¹⁶⁷Soc. Sec. Ruling 85-15 (1985).

IV. The Law

The Need for Medically Determinable Pathology Expected to Cause a Symptom - 20 CFR §§ 404.1529(b), 416.929(b)

(a) Evolution Of Principles

The history of the law in this area may be described as a struggle over the need for objective findings. A primary concern of the federal courts has been to pay benefits to persons who are incapacitated by pain, but who cannot, given the state of the medical art, provide objective evidence of an impairment or its severity.¹⁶⁸ An important responsibility of the Administration is to deny benefits to persons who have little or no impairment, but are feigning severe limitations.¹⁶⁹ Thus, prior to August 1980, the federal courts almost uniformly held that a finding of 'disability' could be based upon incapacitating symptoms alone. Generally, the courts did not change their approach even after the 1968 statutory requirement of "anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques."¹⁷⁰ The Administration, lacking the mandate and the resources to conduct adequate field investigations, continued to assert the need¹⁷¹ for objective medical evidence.

¹⁶⁸The leading case was *Ber v. Celebrezze*, 332 F.2d 293 (2nd Cir. 1964). See also my article, *Social Security Disability Benefits and the Control Theory of Alcoholism*, 50 SOC. SEC. REP. SERV. 893 (1996) for another example of federal courts ordering SSA to do what I think is impossible.

¹⁶⁹OSTERWEIS, *supra* note 8, at 6. As Circuit Judge Kozinski stated in *Fair v. Bowen*, 885 F.2d 597, 602 (9th Cir. 1989), "On one side, incorrect denials of benefits can leave deserving claimants, who are often in precarious financial conditions, without a crucial source of income. On the other, erroneous grants of benefits reward liars at public expense, waste resources that could be put to any number of more productive uses, and may ultimately reduce the level of funding available for people who are legitimately disabled." *Id.* (footnote omitted).

¹⁷⁰42 U.S.C.A. § 423(d)(3); Goldhammer & Bloom, *supra* note 167, at 1119-20.

¹⁷¹First identified in 1948. OSTERWEIS, *supra* note 8, at 23.

The ill-starred "continuing disability investigations (CDIs)" of the early 1980s brought renewed attention to the issue of pain; some observers thought that excessively subjective standards contributed to the "multiplicity of conflicting and confusing court decisions"¹⁷²:

"Many decisions written on [subjective complaints], even in the same circuit, seem to reach different results despite extremely similar factual situations."¹⁷³

In response, the Administration promulgated the regulation,¹⁷⁴ "How we evaluate symptoms, including pain." The language of the one paragraph 1983 regulation is subsumed in the greatly expanded 1991 version¹⁷⁵ now in effect.

In a further attempt to standardize the law, Congress incorporated a pain standard in the Disability Benefits Reform Act of 1984.¹⁷⁶ This was the first and last statutory pain standard in the history of SSA. Although the statutory provision lapsed on January 1, 1987, many of its features are reflected in the present regulations.¹⁷⁷

The 1984 Act mandated further study of the pain issue. This resulted in the two documents most frequently cited in this article: the *Report of the Commission on the Evaluation of Pain* (1986) and the book-length *Pain and Disability* (1987), compiled by the IOM. Neither

¹⁷²OSTERWEIS, *supra* note 8, at 31.

¹⁷³Goldhammer & Bloom, *supra* note 167, at 1129.

¹⁷⁴20 C.F.R. §§ 404.1529, 416.929 (1983).

¹⁷⁵Evaluation of Symptoms, Including Pain, 56 Fed. Reg. 57,928 (1991).

¹⁷⁶Social Security Act, Pub. L. No. 98-460 § 223(d)(5)(A) (1984); § 42 U.S.C. 423(d)(5)(A).

¹⁷⁷Evaluation of Symptoms, Including Pain, 56 Fed. Reg. 57,928 (1991). "These expanded regulations incorporate the terms of the statutory standard for evaluating pain and other symptoms contained in section 3 of the Social Security Disability Benefits Reform Act of 1984 (Pub. L. 98-460)." With regard to "sunsetting" of the DEBRA 1984 pain standard, John Cusker, Esq., writes to me as follows: "Veterans know this, but innocents like myself have been misled by the continued presence of the sunsetted language in published codes, sandwiched between obvious recent amendments. E.g., 42 U.S.C. § 423(d)(5)(A) (1984), sentence one (amended by Social Security Independence Act, Pub. L. No. 103-296 § 107(a)(4)). See also *Bates v. Sullivan*, 894 F.2d 1059, 1064-72 (9th Cir. 1990), overruled in part by *Bunnell v. Sullivan*, 947 F.2d 341, 343 (9th Cir. 1991)."

group recommended any immediate or drastic change in the Administration's approach to the problem.¹⁷⁸ IOM stated: "Disability benefits have never been awarded on the basis of self-reported pain entirely uncorroborated by objective findings, nor should they be."¹⁷⁹

Nevertheless, the Administration and the federal courts continued to disagree about the proper resolution of particular cases. In general, significant court decisions resulted in a series of SSRs¹⁸⁰ and accretions to the regulation. At present, it may be said that the law is set forth in the regulation, "How we evaluate symptoms, including pain"¹⁸¹ amplified by the 1996 SSRs¹⁸² with preexisting and subsequent judicial glosses, which may be laid out along the following continuum.

(1) The need for a medically determinable impairment. This is specified in the Regulation,¹⁸³ and gives rise to the question whether impairments of "unknown etiology" may be disabling.¹⁸⁴ The drafters of the regulation evaded the issue, in the hope of finding a "valid and reliable" test for measuring pain. The regulation is, therefore, in potential conflict with the judicial declaration that pain "real to the patient" may create disability.¹⁸⁵

(2) The relationship between the established impairment and the symptoms alleged. "For example, an impairment that would be expected to cause pain in the lower extremities would not be reasonably expected to cause pain in the upper body."¹⁸⁶ On the one hand, "pain

¹⁷⁸CMN. REP. *supra* note 79, at 71 n.l.; *see also* OSTERWEIS, *supra* note 8, at 265.

¹⁷⁹OSTERWEIS, *supra* note 8, at 9.

¹⁸⁰Former Soc. Sec. Rulings 82-58, 88-13, 87-19c, 90-1p, 95-5p.

¹⁸¹20 C.F.R. §§ 404.1529, 416.929 (1991).

¹⁸²Consideration of Administrative Findings of Fact, 61 Fed. Reg. 34,466 (1996).

¹⁸³20 C.F.R. §§ 404.1529(a), (b), 416.909(a), (b) (1991).

¹⁸⁴Evaluation of Symptoms, Including Pain, 56 Fed. Reg. 57,928 (1991). "We are aware that there are situations in which medical knowledge, understanding, or appropriate medical procedures with regard to pain are inadequate. While we currently know of no valid and reliable method to measure pain, we are interested in development of such a method, and are currently funding research toward this goal. ..." *Id.* at 57,935. No objective test for pain, resulting from this research, has come to the attention of this writer.

¹⁸⁵*Page v. Celebrezze*, 311 F.2d 757 (5th Cir. 1963); *Cohen v. Secretary of the Dept. of Health & Human Serv.*, 964 F.2d 524, 529 (6th Cir. 1992); *Sparks v. Bowen*, 807 F.2d 616, 617-18 (7th Cir. 1986); *Sisco v. U.S. Dept. of Health & Human Serv.*, 10 F.3d 739, 743-45 (10th Cir. 1993); *See also* OSTERWEIS, *supra* note 8, at 55.

¹⁸⁶*Luna v. Bowen*, 834 F.2d 161 (10th Cir. 1987). *Cf. ADAMS, supra* note 6, at 107. But *see* text accompanying note 238.

caused by the impairment may be found to be disabling even though the impairment '*ordinarily does not cause* severe, disabling pain.'¹⁸⁷ On the other hand, the statute refers to "'the pain' alleged";¹⁸⁸ presumably, it does not mean symptoms attributable to some other impairment.¹⁸⁹ Moreover, "direct medical evidence of the cause and effect relationship between the impairment and the degree of the claimant's subjective complaints need not be produced."¹⁹⁰

(3) The relationship between the magnitude of the objective findings and the severity of the symptoms; i.e., "excess pain".¹⁹¹ Judge Kozinski called "excess pain": "a concept only a lawyer could love: vague, statutorily unsupported, metaphysically incongruous."¹⁹² It is, however, the law in most circuits.¹⁹³ Former SSR 88-13 expressed the rule in the following language: "[W]here the degree of pain alleged is significantly greater than that which can be reasonably anticipated based on the objective findings, the adjudicator must carefully explore any additional limitation(s) imposed by the pain on the individual's functional ability beyond those limitations indicated by the objective medical evidence."¹⁹⁴ The 1991 Regulation,¹⁹⁵ while not inconsistent

¹⁸⁷Gallagher v. Schweiker, 697 F.2d 82, 84 (2nd Cir. 1983) (quoting Marcus v. Califano, 615 F.2d 23, 28 (2nd Cir. 1979)) (emphasis added).

¹⁸⁸Bates v. Sullivan, 894 F.2d 1059, 1066 (9th Cir. 1990); Bunnell v. Sullivan, 947 F.2d 341, 350 (9th Cir. 1991).

¹⁸⁹See also Soc. Sec. Ruling 96-7p, and the new Childhood Regulations.

¹⁹⁰Polaski v. Heckler, 739 F.2d 1320, 1321-22 (8th Cir. 1984).

¹⁹¹20 C.F.R. §§ 404.1529(c)(2), 416.929(c)(2) (1983).

¹⁹²Bunnell v. Sullivan, 947 F.2d 341, 351 (9th Cir. 1991) (Kozinski, C.J., concurring).

¹⁹³The string citation, taken from the OHA Circuit Court Reporter, includes: Avery v. Secretary, 797 F.2d 19, 21 (1st Cir. 1986); Dumas v. Schweiker, 712 F.2d 1545, 1552 (2nd Cir. 1983); Green v. Schweiker, 749 F.2d 1066, 1070-71 (3rd Cir. 1984); Walker v. Bowen, 889 F.2d 47, 49 (4th Cir. 1989); Anderson v. Sullivan, 887 F.2d 630, 633 (5th Cir. 1989); Blankenship v. Bowen, 874 F.2d 1116, 1123 (6th Cir. 1989); Penn v. Sullivan, 896 F.2d 313, 315 (8th Cir. 1990); Cotton v. Bowen, 799 F.2d 1403 (9th Cir. 1986); Luna v. Bowen, 834 F.2d 161, 164-65 (10th Cir. 1987); Elam v. Railroad Retirement Bd., 921 F.2d 1210, 1215 (11th Cir. 1991); Brown v. Bowen, 794 F.2d 703, 706 n.4 (D.C. Cir. 1986). The Seventh Circuit adheres more closely to the language of the regulation. Luna v. Shalala, 22 F.3d 693 (7th Cir. 1994).

¹⁹⁴Soc. Sec. Ruling 88-13 (Step II); Similar language is found in the Soc. Sec. Ruling concerning RFC.

¹⁹⁵20 C.F.R. §§ 404.1529(b), (c)(3), 416.929(b), (c)(3). "Once adjudicators determine that the individual has an impairment which is reasonable expected to produce some pain, they must consider all of the evidence relevant to the individual's allegations of pain, even if the

with this concept, directs the adjudicator to consider "other evidence" (described later in this article) when a claimant's symptoms "suggest a greater severity of impairment than can be shown by objective medical evidence alone." The Social Security Rulings¹⁹⁶ issued pursuant to the 1991 Regulation¹⁹⁷ are much less explicit than SSR 88-13 with respect to the requirement for an express "excess pain" analysis.

(4) The relationship between the duration of the objective findings and the duration of the symptoms. This theoretical issue has received little judicial attention, but is relevant, not only to such easy cases as phantom limbs, but the more fundamental question of how the body adjusts to continuously painful stimuli, the problem of secondary gain, and the need to satisfy the twelve month durational requirement¹⁹⁸ for benefits.¹⁹⁹

(5) "[T]he relationship between the medically determinable impairment(s) and the conclusions regarding functioning" (former SSR 95-5p).²⁰⁰ The present Ruling (SSR 96-8p)²⁰¹ states: "In all cases in which symptoms, such as pain, are alleged, the RFC [residual functional capacity] assessment must: Contain a thorough discussion and analysis of the objective medical and other evidence, including the individual's complaints of pain and other symptoms and the adjudicator's personal observations, if appropriate; Include a resolution of any inconsistencies in the evidence as a whole; and set forth a logical explanation of the effects of the symptoms, including pain on the individual's ability to work." Thus, SSR 96-8p elides into:

(6) The relation between the extent of the subjective symptoms (degree of pain) and the extent of the functional limitations.²⁰² As

alleged pain is more severe or persistent than would be expected." Evaluation of Symptoms, Including Pain, 56 Fed. Reg. 57,928 (1991).

¹⁹⁶Soc. Sec. Rulings 96-3p, 96-4p, 96-5p, 96-7p, 96-8p.

¹⁹⁷These replace both Soc. Sec. Ruling 88-13 and its successor, Soc. Sec. Ruling 95-5p.

¹⁹⁸Twelve months. 42 U.S.C. 416(i)(1).

¹⁹⁹In addition, recall that "'sporadic diversions' ... do not establish that a person is capable of engaging in substantial gainful activity." *Byron v. Heckler*, 742 F.2d 1232, 1235 (10th Cir. 1984).

²⁰⁰Former Soc. Sec. Ruling 95-5p, 60 Fed. Reg. 55,406 (1995). Soc. Sec. Ruling 95-5p also required "a discussion of why reported daily activity limitations or restrictions are or are not reasonably consistent with the medical evidence." *Id.* at 1.

²⁰¹61 F.R. 34,478 (1996).

²⁰²20 C.F.R. §§ 404.1529(c), 416.929(c).

stated by the IOM: "There is an imperfect correspondence between severity of pain and dysfunction. People can have severe pain with minimal functional limitations or minimal pain with severe limitations."²⁰³ The IOM concluded that "attempts to draw inferences about the ability of a patient to engage in gainful employment on the basis of pain measurement are futile."²⁰⁴ and that "a serious problem is posed by having to decide how much dysfunction can be attributed to pain when the severity [of the pain] cannot be measured."²⁰⁵ However, just as the Courts require an "excess pain" analysis, it seems appropriate to inquire whether, despite significant pain, a particular claimant can still function.

(7) The degree of functional limitation necessary or appropriate for a finding of disability. "We do not apply a 'standard' of acceptable pain."²⁰⁶ The "average person" test was rejected the courts many years ago;²⁰⁷ the present rule is that the person must be so impaired that he cannot do his past work or any other jobs existing in significant numbers in the economy. While, in rare instances, even a "non-severe" impairment may be sufficient to preclude past work, in general, to be disabling, the claimant's impairments must have more than a minimal impact on his ability to perform basic work activity.²⁰⁸ Certainly, "disability requires more than mere inability to work without pain."²⁰⁹

(8) Mitigation of Symptoms. The issues include compliance with prescribed treatment²¹⁰ and the effects and side effects of medication.²¹¹ One possible issue arises from Pub. L. 104-121, which denies benefits to persons whose drug addiction or alcoholism is material to a finding of disability: Is a "side effects" analysis appropriate to substance abuse which is iatrogenic, or an attempt at self-medication?²¹² Note that "[i]t is impossible to assess pain in the

²⁰³OSTERWEIS, *supra* note 8, at 8.

²⁰⁴*Id.* at 228.

²⁰⁵*Id.* at 14; *See also* former Soc. Sec. Ruling 82-58.

²⁰⁶Evaluation of Symptoms, Including Pain, 56 Fed. Reg. 57,928 (1991).

²⁰⁷*Ber v. Celebrezze*, 332 F. 2d 293 (2nd Cir. 1964).

²⁰⁸20 C.F.R. §§ 404.1521, 416.921 (1991).

²⁰⁹*Dumas v. Schweiker*, 712 F.2d. 1545, 1552 (2nd Cir. 1983).

²¹⁰20 C.F.R. §§ 404.1530, 416.930 (1991).

²¹¹20 C.F.R. §§ 404.1529(c)(3)(iv), 416.929(c)(3)(iv) (1991).

²¹²*See* OSTERWEIS, *supra* note 8, generally at 177-78.

addicted individual, for the patient's complaints are woven into the need for medication."²¹³

(9) Restoration of Function. With the failure of the 1965 Beneficiary Rehabilitation Program,²¹⁴ vocational rehabilitation dropped out of consideration as a significant factor in disability determination: The regulations which might have encouraged such rehabilitation are generally lacking in teeth.²¹⁵ However, to be eligible for state or federal vocational rehabilitation, claimants must "demonstrate a future likelihood of employment";²¹⁶ accordingly, referral to such programs is of some evidentiary significance.²¹⁷

(10) Finally, of course, hairs can (and have) been split at each step of the sequential evaluation.²¹⁸

(b) Evidentiary Considerations

(1) Overview

There are at least two basic approaches to the law of evidence in Social Security adjudication: the adversarial and the judicial. The distinction is critical to this writer's approach to the problem of evaluating pain.

Judges believe (or say that they believe) that in law there is truth: By following the map of regulations, listings and grids, we will come to a "correct" result. For advocates, the rules are swords and shields in a battle to achieve a specific result: Claimant's representatives seek an award of benefits. Since the agency is not represented at Social Security hearings, the Administrative Law Judge, wearing his (or her) "three hats," may use the same rules in different ways when developing,

²¹³ADAMS, *supra* note 6, at 111.

²¹⁴OSTERWEIS, *supra* note 8, at 253.

²¹⁵See 20 C.F.R. §§ 404.1596(b)(2)(iii), 404.422; there are no comparable SSI provisions.

²¹⁶OSTERWEIS, *supra* note 8, at 156.

²¹⁷*Id.* at 246. Regarding return to work as a condition of receiving Workers Compensation benefits.

²¹⁸Step II (severe): see Soc. Sec. Ruling 96-3p; Step III (meets or equals listing); cf. former Soc. Sec. Ruling 82-58 with 56 Fed. Reg. 57928, 57936; Step IV and V (past relevant work and other work): see Evaluation of Symptoms, Including Pain, 56 Fed. Reg. 57,928 (1991).

testing, and deciding the factual issues. The evidentiary rules are discussed in this light.

(i) Competence

The regulations²¹⁹ state that we "may receive evidence at the hearing even though the evidence would not be admissible in court under the rules of evidence used by the court."²²⁰ However, the regulations do not tell us what evidence we must receive.

Perhaps the most important evidentiary rule with respect to the evaluation of pain involves lay opinion and speculation.²²¹ Rule 602 of the Federal Rules of Evidence requires a witness to have "personal knowledge" of the matter to which he testifies; the absence of this rule from Social Security adjudication has major consequences for the evaluation of subjective symptoms.

For example, every law student knows that the question "How far did you walk?" when relevant, is proper under the Federal Rules. If the witness replies "From my house to the post office" the answer is unobjectionable. If the next question asked is "How far is that?" a

²¹⁹20 C.F.R. §§ 404.950(c)/416.1450(c) (1986).

²²⁰In fact, however, we may not receive evidence that is subject to a constitutional or specific statutory exception; *see, e.g.*, C. H. KOCH, JR., 1 ADMINISTRATIVE LAW & PRACTICE § 6.33 (1985); *cf.* MCCORMICK ON EVIDENCE §§ 72, 117 (E. W. Cleary et al., eds., 3rd ed. 1984); K. C. DAVIS, 3 ADMINISTRATIVE LAW TREATISE § 16.10 (2nd ed. 1980).

²²¹*See* 20 C.F.R. §§ 404.1512, 416.912 and treatises cited in previous footnote. Regarding an ALJ's duty to develop record, *see* Hallex I-2-500 (OFFICE OF HEARINGS AND APPEALS, SOCIAL SECURITY ADMINISTRATION, HEARINGS APPEALS AND LITIGATION LAW MANUAL (1992)). Regarding lay opinion, *see* *Nguyen v. Chater*, 100 F.3d 1462, 1467 (9th Cir. 1996) (lay witness testimony as to a claimant's symptoms or how an impairment affects ability to work is competent evidence, and cannot simply be ignored by ALJ); *Smollen v. Chater*, 80 F.3d 1273, 1288-89 (9th Cir. 1996) (ALJ cannot reject lay witness testimony merely because relatives are presumed biased, nor because medical records do not document alleged symptoms); *Doddrill v. Shalala*, 12 F.3d 915, 919 (9th Cir. 1993) (ALJ cannot dismiss third party witness testimony merely because claimant lacks credibility; reasons germane to each witness are required). Other Circuits differ from the Ninth with respect to the weight of such testimony. *See* *Books v. Chater*, 91 F.3d 972 (7th Cir. 1996) (ALJ need not address essentially redundant evidence); *Ostronski v. Chater*, 94 F.3d 413, 419 (8th Cir. 1996) (credibility finding not required); *Kisling v. Chater*, 105 F.3d 1255, 1258 (8th Cir. 1997) (ALJ may disbelieve witness merely corroborating claimant); *Lawrence v. Chater*, 107 F.3d 674, 677 (8th Cir. 1997) (husband's testimony rejected); *see also* ADAMS, *supra* note 6, and *Adams v. Chater*, 93 F.3d 712, 715 (10th Cir. 1996) (specific findings on credibility not required where decision reflects consideration of witness' testimony).

student will immediately realize that a truthful answer may be accurate ("four blocks"), or wildly inaccurate ("two miles"), based upon witnesses' well known propensity to misjudge time, distance, and the like.²²²

If the examiner's first question, however, was "How far can you walk?" there would be an immediate and valid objection. If the witness were permitted to answer, an honest, thoughtful response would be "I don't know; that would depend upon many circumstances, including my motivation." It is therefore remarkable that questions such as this are permitted, even encouraged, by Social Security's protocol for evaluating pain.

Similarly, Rule 803(4) of the Federal Rules of Evidence permits, as an exception to the hearsay rule, "statements made for purposes of medical diagnosis or treatment and describing medical history, or past or present symptoms, pain, or sensations, ... insofar as reasonably pertinent to diagnosis or treatment." The absence of a hearsay rule from Social Security adjudication not only permits such evidence (when it is generated for purposes other than diagnosis or treatment), but allows the receipt of unsworn, even unsigned, questionnaires and statements containing opinion and speculation such as those discussed in the first example.

Finally, not to belabor the point, Federal Rule of Evidence 803(3) permits, as a hearsay exception, "[a] statement of the declarant's then existing state of mind, emotion, sensation, or physical condition (such as ... mental feeling, pain and bodily health), but not including a statement of memory or belief to prove the fact remembered or believed [unless it relates to the declarant's will]." Again, this would appear to represent an advance over Social Security's approach, particularly in view of "the completeness with which pain is often forgotten once it is over."²²³

(ii) Direct Observation: "Sit And Squirm" Evidence

²²²See, e.g., J. WIGMORE, THE PRINCIPLES OF JUDICIAL PROOF 439 (1913).

²²³OSTERWEIS, *supra* note 8, at 102, 226; Cf. "Every one will readily allow, that there is a considerable difference between the perceptions of the mind, when a man feels the pain of excessive heat, or the pleasure of moderate warmth, and when he afterward recalls to his memory this sensation, or anticipates it by his imagination." David Hume, *An Enquiry Concerning Human Understanding*, 35 GREAT BOOKS OF THE WESTERN WORLD 455 (1952).

If, on the one hand, the invitation of the regulations is to admit everything, some Circuits would have the Administrative Law Judge ignore the evidence of his or her own senses, rejecting the ALJ's observations as "sit and squirm jurisprudence."²²⁴ Adhering to this rule, the courts have used language that is sometimes less than generous.²²⁵

I contend that acute physical pain (such as that produced by striking one's thumbnail with a hammer) can be detected by an Administrative Law Judge as well (or as poorly) as by anyone else, for reasons I have explained at length. The observable signs of acute pain (touching or guarding the painful area, grimacing, or bracing, not to mention, in extreme cases, smarting, writhing, screaming, and fainting) are so obvious that they are rarely articulated except in the narrative reports of emergency room pediatricians²²⁶ or the testimony of witnesses to bodily injury. I may be wrong, but I suspect that even animals, such as horses and dogs, can sometimes recognize another creature in pain. Certainly, juries make this assessment based on their observation²²⁷: "The exhibition of a wound or physical injury, e.g., the injury sustained by a plaintiff in a personal injury action, will frequently be the best and most direct evidence of a material fact."

What the courts do permit, apparently, is reliance upon such observations for the purpose of evaluating the credibility of the witness' testimonial assertions (i.e., demeanor evidence) and "ordinary techniques of credibility evaluation," including consideration of activities of daily living, failure to seek medical treatment, reputation for veracity, prior inconsistent statements, and being less than candid in other respects.²²⁸

As Judge Halligan pointed out, the regulations²²⁹ "implicitly note the unreliable character of verbal reports of pain and of its intensity by requiring evidence of nonverbal, behavioral indications of

²²⁴Abeuf v. Schweiker, 649 F.2d 107, 113 (2nd Cir. 1981); Perminster v. Heckler, 765 F.2d 870, 872 (9th Cir. 1985).

²²⁵See, e.g., Day v. Weinberger, 522 F.2d 1154, 1156 (9th Cir. 1975).

²²⁶T. Ed Terndrup, *Pediatric Pain Control*, 27 ANN. EMERG. MED. 466-70 (1996).

²²⁷MCCORMICK ON EVIDENCE § 215 (E. W. Cleary et al. eds., 3rd ed. 1984).

²²⁸Of course, an actor can mimic the signs of pain, and courts are usually more concerned with ALJs' observations suggesting the absence of pain.

²²⁹20 C.F.R. §§ 404.1529, 416.929.

pain, or rather the behavioral effects of pain on function in life and work."²³⁰ The most recent Social Security Rulings²³¹ address the issue by stating that an Administrative Law Judge is not free to accept or reject pain complaints solely on the basis of his or her observation of the claimant, but should consider such observations in evaluating the claimant's overall credibility. Ironically, therefore, the present Rulings²³² appear to endorse the view that pain behaviors cannot be used to determine whether the witness is in pain; they can only be used to determine whether the witness is telling the truth!²³³

(2) Evaluation Of The Evidence

What the regulations do require in pain cases is a detailed description of symptoms. The regulations say nothing about the reliability or truthfulness of the report of symptoms, nor do they tell us how to interpret the details that have been elicited. As a checklist for gathering details, I offer the following analysis; it is, hopefully, applicable to both the judicial and adversarial approach to the evidence, mentioned above. Interpretation of the details is respectfully deferred to the medical experts.

(i) Documents

Physicians have different philosophies about the recordation of symptoms, particularly pain.²³⁴ For hospital in-patients, symptoms are most likely to be recorded in Nurses' Notes.²³⁵ In the absence of a hearsay rule, moreover, it is necessary to distinguish complaints in

²³⁰P. Halligan, *Credibility, Chronic Pain, and Converted Mental Conflict: Some Distinctions for Adjudicators* 38 SOC. SEC. REP. SERV. 793, 796 (1993).

²³¹Soc. Sec. Ruling 96-7p, 61 Fed. Reg. 34,483 (1996).

²³²Soc. Sec. Rulings 96-3p, 96-4p, 96-5p, 96-7p, 96-8p.

²³³"The adjudicator is not free to accept or reject the claimant's subjective complaints *solely* on the basis of personal observations. Subjective complaints may be discounted if there are inconsistencies in the record as a whole." *Polaski v. Heckler*, 739 F.2d 1320 (8th Cir. 1984). There are, of course, many other evidentiary issues that may be considered. For example, rules as to burden of proof differ in DIB and SSI cases; the rules are beclouded by the ALJ's duty to develop the record, etc.

²³⁴W. L. HURR, ATTORNEYS' GUIDE TO MEDICAL RECORDS § 201 (1993).

²³⁵See, generally, *id.* at § 208.1.

contemplation of treatment from self-serving statements in pursuit of benefits.

(ii) Claimant's Testimony

Many people have difficulty putting their sensations into words, and, considering the views of the Eighteenth Century philosophers, it is remarkable that symptoms can be communicated at all. Certainly, as previously noted, educational, cultural, and language considerations must be explored; remembered pain is always problematic; the symptoms themselves may limit expression; and underlying pathology (alexithymia, Ganser's syndrome,²³⁶ etc.) may play a role.

The details to be elicited²³⁷ include the location of pain, with broader consideration of whether the site affects function. With respect to orthopedic impairments, appropriate dermatomal distribution must be balanced against such phenomena as referred pain. "Any pain, once it becomes chronic, may spread quite widely in a verticle direction on one side of the body."²³⁸ Note, however, that "[p]ain intensity seldom has diagnostic value -- in the head or in any other somatic location."²³⁹

The quality of pain (its aversiveness or unpleasantness), as opposed to its intensity or duration, is another factor to be considered: not all sensations described as painful are equally distracting or limiting; suffering should be distinguished. The body's natural defenses (modulation and spontaneous analgesia)²⁴⁰ may bear on the duration of

²³⁶See, e.g., H. Kaplan & B. Sadock, MODERN SYNOPSIS OF COMPREHENSIVE TEXTBOOK OF PSYCHIATRY III 654 (1981). "The most remarkable feature of this psychiatric disorder is the phenomenon of the patient's giving an incorrect and often ridiculous reply [to questions]" *Id.*

²³⁷20 C.F.R. §§ 404.1529, 416.929 and former Soc. Sec. Ruling 88-13; see also Soc. Sec. Ruling 96-7p. "Whenever pain, by its intensity, duration, and the circumstances of its occurrence appears to be abnormal, or when it constitutes one of the principle symptoms of disease, the physician must attempt to reach a tentative decision as to the mechanism of its production and cause. This is accomplished by a thorough interrogation of the patient, carefully seeking out the main characteristics of the pain in terms of its location, provoking and relieving factors, quality and time-intensity attributes, mode of onset, duration, severity and time of occurrence." These diagnostic features are discussed in detail in HARRISON, *supra* note 51; see also ADAMS, *supra* note 6, at 108.

²³⁸ADAMS, *supra* note 6, at 107.

²³⁹HARRISON, *supra* note 51, at 65.

²⁴⁰OSTERWEIS, *supra* note 8, at 134.

pain, and should be weighed with such factors as chronicity, recurrence, exacerbations and remissions. Variations in the quality of symptom reports and descriptions might, if possible, be compared to actual changes in symptoms over time. Precipitating and aggravating factors should be determined, as well as alleviating factors and circumstances (E.g., is work an anodyne?).

The Visual Analogue Scale (VAS) is a conventional method for measuring the subjective intensity of pain. It usually consists of a 10 cm line, labeled at one end "no pain" and at the other "the worst pain imaginable."²⁴¹ The Numerical Rating Scale ("1" to "10"), administered orally, is a familiar variation.²⁴² We have spoken about the need for objective findings and the problem of "excess pain."

Finally, the entire pain experience described in this article, from nociception through perception, interpretation, coping and communication, may afford opportunities for testimonial scrutiny.

(iii) Third-Party Evidence: Treating Physician Rule

Third party evidence with respect to pain includes a parent's description of a child's symptoms,²⁴³ "observations recorded at hearings,"²⁴⁴ and "observations by our employees,"²⁴⁵ which raises the due process issue of confrontation and cross-examination.²⁴⁶ The IOM²⁴⁷ notes the limitations of "observer pain judgements in chronic pain settings," but indirect observations by examining physicians (disparity between the patient's responses on formal examination, when compared to similar movements and postures at other moments) is a

²⁴¹*Id.* at 214.

²⁴²*Id.*

²⁴³20 C.F.R. § 416.928. Pain is a symptom and by definition is a person's description of his own impairment. *Id.* Thus, most third party evidence refers to complaints, reports of symptoms, behaviors, etc.

²⁴⁴Soc. Sec. Ruling 96-7p (1996).

²⁴⁵20 C.F.R. §§ 404.1529, 416.929.

²⁴⁶*Cf.* the Preamble to 20 C.F.R. §§ 404.152, 416.927; *Standards for Consultive Examinations*, 56 Fed. Reg. 36,932 (1991) (regarding the need for supporting detail in medical reports). "We believe that the use of the factors specified in [the regulation] is a reasonable substitute for the scrutiny that any opinion would be subjected to if it were placed before a court in an adversarial context." *Id.* at 36,933.

²⁴⁷OSTERWEIS, *supra* note 8, at 217.

mainstay of orthopedic disability evaluation. Evidence of a claimant's pain behaviors is obviously highly relevant. The claimant's work history is also a factor to be considered.²⁴⁸

The "treating physician rule" as expressed in the present regulation²⁴⁹ does not distinguish the assessment of symptoms from other aspects of the physician's medical opinion, except in the context of the following example:²⁵⁰ "[I]f your ophthalmologist notices that you have complained of neck pain during your eye examinations, we will consider his or her opinion with respect to your neck pain, but we will give it less weight than that of another physician who has treated you for neck pain." However, the regulation makes clear that²⁵¹ "we use medical sources, including your treating source, to provide evidence, including opinions, on the nature and severity of your impairment(s). Although we consider opinions from treating and examining sources on issues such as whether your impairment meets or equals [a listing, your residual functional capacity, or the application of vocational factors, we] will not give any special significance to the source of the opinion on these issues." However, a complete discussion of the various Circuits' approach to the treating physician rule is beyond the scope of this article.²⁵²

(iv) Objective Tests For Pain (Or Its Absence)²⁵³

If pain could be extracted like blood plasma, it could be objectively quantified; alas, this is not possible. Accordingly, tests for pain are, at best, indirect.

Objective tests, such as X-rays, do not measure pain. Indeed, as the IOM noted, "in 95% of cases [of low back pain, X-rays of the lumbar spine] do not provide diagnostic information."²⁵⁴ Although "special imaging of the spinal canal by myelography and [MRI], as well

²⁴⁸See *Benskin v. Bowen*, 830, F.2d 878, 883 (8th Cir. 1987).

²⁴⁹20 C.F.R. §§ 404.1527, 416.927 (1991).

²⁵⁰20 C.F.R. §§ 404.1527(d)(2)(ii), 416.927(d)(2)(ii) (1991).

²⁵¹20 C.F.R. §§ 404.1527(e)(2), 416.927(e)(2) (1991).

²⁵²See, e.g., J. Maccaro, *The Treating Physician Rule and the Adjudication of Claims for Social Security Disability Benefits*, 64 N.Y. STATE BAR J. 28 (1992).

²⁵³OSTERWEIS, *supra* note 8, at 211 n.1.

²⁵⁴*Id.* at 192.

as nerve conduction tests, electromyography, and thermography" can sometimes "provide useful diagnostic information [regarding back pain]" a "definite diagnosis can only be expected in 5-10% of patients with chronic low back pain."²⁵⁵ Moreover, thermography, which provides a striking visual representation of temperature variations on the surface of the skin, is no longer recognized by SSA as a reliable medical test for pain.²⁵⁶ While Dr. Simons cites authority for the proposition that "pressure threshold measurements ... provide objective substantiation of clinical findings associated with myofascial trigger points,"²⁵⁷ other research suggests that manual palpation is no less reliable than assessment by pressure algometer, and that "[t]ender point scores in fibromyalgia reflect individual differences in mean pain thresholds as well as individual tender point profiles."²⁵⁸

Among the many instruments for the self-report of pain,²⁵⁹ the McGill Pain Questionnaire (MPQ) is perhaps the best known. Twenty sets of words describe different qualities and intensities of pain along three dimensions, sensory, affective, and evaluative.²⁶⁰ According to the IOM, the Minnesota Multiphasic Personality Inventory (MMPI) is useful in correlating objective pain behaviors with downtime,²⁶¹ but the Commission on the Evaluation of Pain²⁶² previously concluded that the MMPI had "not yet demonstrated the kind of predictive validity essential to precise measurements about pain...." Among the pain questionnaires developed by SSA, The Pain Report²⁶³ is perhaps the most detailed.

Finally, of course, are the "tests" such as Waddell's (Appendix II), which, in effect, trick the examinee into complaints or behaviors inconsistent with the presence of known or alleged painful pathology ("painful hair" etc.). Even more telling are the techniques long used by

²⁵⁵*Id.* at 192-93, 141.

²⁵⁶Evaluation of Symptoms, Including Pain, 56 Fed. Reg. 57,928, 57,940 (1991) (thermography "not widely accepted").

²⁵⁷OSTERWEIS, *supra* note 8, at 289 (citations omitted).

²⁵⁸J.W.G. Jacobs et al., *Are Tender Point Scores Assessed by Manual Palpation in Fibromyalgia Reliable?* 24 SCAN. J. RHEUMATOL 243-47 (1995).

²⁵⁹OSTERWEIS, *supra* note 8, at 215.

²⁶⁰*Id.*

²⁶¹*Id.* at 222.

²⁶²CMN. REP., *supra* note 79, at 84.

²⁶³SSA-3370-BK (May 95).

personal injury and worker's compensation defense investigators: videotaping the individual in activities wholly inconsistent with the functional and sensory complaints alleged.

V. Conclusion

"Because adequate technology for the objective assessment of chronic pain is not available, the [IOM] committee believes that attempts to draw inferences about the ability of a patient to engage in gainful employment on the basis of pain measurement are futile. Instead, disability evaluation efforts should focus on pain-related dysfunction rather than on pain alone."²⁶⁴ "Ultimately, the presence of pain in another individual is always inferred."²⁶⁵

If, as virtually everyone agrees, the presence of pain in another person is ultimately a question of credibility, the policy choices become clear. Limiting the payment of disability benefits to those who have an objectively determinable medical condition known to cause pain may be fiscally sound, but it excludes from coverage that very large class of persons whose impairment is known only by the pain it causes; especially persons who suffer from back and head pain. It may well be that many of such persons do not have pain of such severity that it precludes substantial activity for any continuous period of twelve months; it may also be true that some people with objectively serious impairments in fact experience very little functional limitation as a result of their symptoms. Moreover, under the present system, the evaluation of pain is too often a matter of expressing the correct verbal formula, while searching for consistencies or inconsistencies in the linguistic choices of claimants, their physicians and friends.

²⁶⁴OSTERWEIS, *supra* note 8, at 228.

²⁶⁵*Id.* at 142.

There is, I suggest, a better, fairer, more accurate and compassionate way. The actuarial value of a Social Security disability award is substantial.²⁶⁶ A field investigator who uncovered only one case of malingering each year would justify the cost of investigation, and, less tangibly, enhance program integrity. A routine investigation of all disability claims would not be unduly intrusive; on the contrary, having the authority to recommend the allowance of benefits to persons observed to be impaired, and to help such persons obtain benefits in the absence, perhaps, of sufficient objective findings, a field investigator should be seen by the honest members of the claimant community in a generally favorable light. The need for adequate fact gathering is clearly implied by every Federal court decision in this area, and is the logical next step in disability evaluation. Knowing what we do about the reliability and validity of the present system of determining disability, particularly pain, investigation may well be worth a try.

²⁶⁶Estimated at \$200,000 in Association of ALJS Newsletter, 2 (Special Edition, February 1997).

Appendix I

Common Treatments for Chronic Low Back Pain

Bed rest or restricted activity (Bed rest and restricted activity lasting for weeks or months are "difficult to rationalize for patients with nonradiating acute low back pain and exacerbations of chronic low back pain.... Clinical efforts should be directed at relieving pain... while the patient continues to be as active as possible." [IOM, *supra* note 8, at 202]); **exercises**; physical therapy with **cold, heat and/or massage**; **corsets**; **traction**; **trigger point injections** with local anesthetics; **"stretch and spray"**; injections of parenteral and **epidural steroids** ("Peripheral nerve blocks are commonly used by anesthesiologists diagnostically to localize the source of pain. Occasionally, a temporary diagnostic block proves therapeutic.... However, these injections are rarely included as regular parts of chronic pain programs." [IOM, *supra* note 8, at 241]); intradiscal **chymopapain** [a polysaccharide-splitting enzyme of plant origin is injected into the nucleus pulposus; its lytic action causes a decrease in intradiscal pressure. ADAMS, *supra* note 6, at 170]; **diathermy**; **transcutaneous nerve stimulation** ("Although TENS helps some chronic pain patients, how any individual patient will respond is unpredictable, and its benefit for pain relief is likely to fade with time. [One study suggested that TENS was] not quite as effective as vibration." [IOM, *supra* note 8, 237; See Also ADAMS, *supra* note 6, at 104]); **biofeedback** ("rarely helpful for low back pain" [IOM, *supra* note 8, at 240]); **behavioral modification**; **radiation**; **surgery** (rhizotomy; spine surgery: "Even when surgery is effective in relieving sciatica, comparisons of surgical and nonsurgical treatments reveal no difference in outcomes after two years." [IOM, *supra* note 6, at 204]); **ultrasound** [IOM, *supra* note 8, at 237]; **instruction in body mechanics**; **relaxation training**; **psychotherapy**; **hypnosis**; **acupuncture**; **acupressure**; **hydrotherapy**; **herbs**; **placebos** [ADAMS, *supra* note 6, at 106] and **prayer**. According to the IOM [IOM, *supra* note 8, at 153, 237], **chiropractic** "rarely provides more than temporary relief" from chronic back pain.

Oral drugs such as **analgesics**, **muscle relaxants** and **anti-depressants**, play a significant role in the relief of chronic pain. However, "substance abuse in the form of prescription drugs and/or

alcohol is a frequent stigma of the chronic pain syndrome." [AMA GUIDES, *supra* note 82, at 249] The IOM notes that there is "controversy" in the medical community about the long-term use of **opiates** for nonmalignant chronic pain. [IOM, *supra* note 8, at 203, see 173] Moreover, "physicians need to be alert to the possible unintended, often adverse, side effects of drugs, including physical and psychological dependence, impaired motor coordination, altered daytime functioning, and symptoms of withdrawal when medication is discontinued." [IOM, *supra* note 8, at 203] "The ... types of medication with a substantial risk of adverse alterations of mood and functioning [depressed mentation, mental clouding, sedation] are ... **benzodiazepines** [used to relieve muscle tension, anxiety or insomnia] and **barbiturate** and **nonbarbiturate hypnotics**." [IOM, *supra* note 8, 173] **Aspirin** and other non steroidal anti-inflammatory drugs (NSAIDs) have already been mentioned [*supra*; see also 1994 CUR. DX. & TR., *supra* note 54, at 10] **Patient Controlled Analgesia (PCA)** is another treatment option. [1994 CUR. DX. & TR. *supra* note 54, at 8]

Appendix II Waddell's and other Tests for Malingering

Based on Decision Writer Training, Arlene Pfister, M.D., September 1995

1. "Tripod test" (below).
2. Overreaction to stimuli.
3. Pressure on top of head ("axial loading") should not produce neck or back pain.
4. If motion on testing is ratchety [cog wheel] or "give way," patient is trying to feign weakness, but doesn't know how.
5. "Stocking glove distribution" would need huge tumor pressing on all nerves in limb [inappropriate dermatome distribution].

6. Bending knees and twisting side to side should not produce back pain (motion is in knees).

Other Tests

"A patient is asked to say 'yes' each time various ... body parts are touched. A patient simulating sensory loss may say 'no' in response to tactile stimulation." [ADAMS, *supra* note 6 at 120]

Practice Management Associates, Inc., Chiropractic/Orthopedic/Neurological Examination:

Tripod Test: Patient seated, extend one leg. Rationale: positive for sciatic pain ("seated Lasegue").

Hoover's Sign: Patient supine. Stabilize calcaneus of good leg, have patient raise bad leg. Rationale: no downward pressure with good leg = malingering.

Gaenslen's Test: Patient to side of table, flex thigh to chest, hyper-extend opposite leg off table. Malingering if pain not detected when each leg is tested.

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